THE FINAL REPORT
OF THE

MAYOR'S
ACTION TASK FORCE
ON
DISCHARGED
PSYCHIATRIC PATIENTS

FEBRUARY, 1984

CHAIRPERSON:
DR. REVA GERSTEIN, O.C., PSYCH.C.

Even in the darkest of times, we have the right to expect some illumination. It may well come less from theories and concepts than from the uncertain flickering and often weak light that some men and women, in their lives and works, will kindle and shed over the time span given to them on earth.

Hannah Arendt
Men in Dark Times

This report is dedicated to the many fine people in this City who have laboured with dedication and vision, often with inadequate resources, to create a society where the psychiatrically disabled can realize their potential.

CONTENTS

Acknowledgements: ....Page iii

Foreword: 1

Mandate from Toronto City Council: 2

1. Introduction 4

2. Response to the Preliminary Report 8

3. Summary of Recommendations 17

4. The Historical Context: Perspectives on Mental Health and Illness 23

5. The Toronto Situation - A Review of the Literature 29

6. Housing 46

7. Crisis Intervention Services 62

8. Work: Towards a Range of Opportunities 79

9. Coordination of Aftercare Services 91

10. Attitudes: Barriers to Community Mental Health 95

Appendices

A. Prototype Contract for Contract Aftercare Project (CAP)........ 97

B. A comparison of physical and personal care standards in regulating boarding homes 109

C. Legal Analysis - Parkdale Community Legal Services 134

D. Greater Vancouver Mental Health Service: Venture. In-Patient and After-Hours Psychiatric Emergency Service (A.H.P.E.S) Expenditures 1982/1983 140

E. Proposed Crisis Centre (15 Residents) Funding Estimates 141

F. List of people consulted during the course of the Task Force: February 1983 - January 1984 143

G. List of Task Force Meetings, Topics and Presenters 149

H. Response to Reports from City of Toronto Special Committees .. 153

ACKNOWLEDGEMENTS

Although I was appointed as a "one person Task Force", much of what has been accomplished over the past year is due to the combined thought and effort of many concerned individuals. This Task Force benefitted greatly from the considerable resources made available through the Toronto Department of Public Health. In particular, the decision to second the Health Advocate, Marilou McPhedran, to act as the Task Force Coordinator has proven to be both efficient and effective and I have valued her ability to combine legal expertise with other disciplines.

I welcomed the suggestion for an Advisory Committee and am indebted to Ms. McPhedran, David Goyette, Alderman David Reville and Executive Alderman Anne Johnston for their assistance in assembling a committee which has provided me with invaluable information and support.

This report has grown from a twenty page summary to over one hundred pages. Even though my mandate did not allow for original research to be done, the extensive research and writing already completed needed to be assembled and commented upon. I have never believed that "big is better" when it comes to reports but as my work progressed, it became clear that a much more comprehensive document was warranted.

I wish to thank those who have been of principal assistance to Marilou and me in the face of a very demanding production schedule:

Liss Jeffrey, who has written extensively in this field, is currently an instructor in Communications and a graduate student in the Environmental Studies Department at York University;

Cindy MacDougall, who provided us with needed legal research, is a third-year law student at the University of Toronto;

Linda Rosenbaum, Health Promotion Officer and Anne Moon, Public Relations Coordinator with Toronto's Department of Public Health, who have provided invaluable editorial and production assistance on very short notice;

Pauline Fox, the present Task Force Secretary and Elizabeth Walker, the former Task Force Secretary, both of whom worked long hours before the video display terminal to help produce what I hope will prove to be a useful document, for years to come.

Many, many people gave generously of their time and skills. The preparation of this report was greatly aided by D'Arcy Farlow, Susan Atkinson, Ian King, Bob Stone, and Marcia Moss.

My sincere thanks go to each of the members of the Advisory Committee, who have given so generously of their time and skills to this Task Force:

Pat Capponi	Editor, Cuckoo's Nest
Al Erlenbusch	Ministry of Health
Karen Goldenberg	Community Occupational Therapy Associates
David Goyette	Office of the Mayor
John Kamin	Parkdale Activity & Recreation Centre - Board
Alexander S. Macpherson	Medical Officer of Health, City of Toronto
Mary Marshall	Canadian Mental Health Association
Ken Munro	On Our Own
Mary Ellen Polak	Supportive Housing Coalition of Metro Toronto
Joel Shapiro	Ministry of Community and Social Services

FOREWORD:

On February 9, 1983 Mayor Arthur Eggleton appointed Dr. Reva Gerstein to chair an inquiry into the situation surrounding discharged psychiatric patients living in the City of Toronto. The Mayor asked Dr. Gerstein to prepare a final report from this Task Force which developed a "co-ordinated problem-solving approach" to the concerns raised during the course of her inquiry. As well, Mayor Eggleton stipulated that the title of the Task Force include the word "Action". It was anticipated that Dr. Gerstein and her advisors would actively respond to events and problems throughout the course of the inquiry, as they arose, rather than restricting themselves to making recommendations in a final report. "Action" was also used to indicate that the Mayor and City Council had made a commitment toward immediate implementation of recommendations wherever possible.

Therefore, this report is not a complete catalogue of the work undertaken by the Task Force in the past year. Rather, the most significant problems facing discharged psychiatric patients are identified and discussed. Proposals are included that address five of those problem areas: 1) housing, 2) crisis intervention, 3) coordination of aftercare services, 4) meaningful work, and 5) public education. All of these proposals are predicated on coordination and cooperation among all three levels of government: the City of Toronto, Metropolitan Toronto, and the Province of Ontario.

At its meeting of May 16, 1983, the Council of the City of Toronto decided that the Task Force's mandate would include the appointment of an Advisory Committee (the members of this committee are listed on page iv of this report). As well, it was decided that public meetings would be held on a regular basis and that the Preliminary Report would be discussed at an evening public meeting on November 30th, 1983 in the Council Chambers. Presentations made at this meeting were considered when preparing this Final Report to be made to members of Council. A list of deputants to this and the other public meetings can be found in Appendix G.

In addition to the public meetings, consultations were held on a more informal basis with members of the Advisory Committee and many others, listed in Appendix F.

MANDATE FROM TORONTO CITY COUNCIL

In his inaugural speech to City Council on December 3, 1982, Mayor Arthur Eggleton outlined a proposal for the Action Task Force to examine and advocate the needs of discharged psychiatric patients in Toronto. Mayor Eggleton acknowledged the many previous attempts to improve the quality of life for these citizens, but he noted that "It is clear that we continue to face the unacceptable reality that many ex-patients are not provided with a satisfactory level of accommodation and aftercare."

Mayor Eggleton made reference to the several initiatives taken by concerned officials at the municipal and provincial levels of government and indicated his concern "about the need for a focus for the City's work, and the ability of Council to have a consensus of views placed before it at one point in time."

In outlining the purpose of the Task Force, the Mayor noted the existence of sufficient documentation regarding discharged psychiatric patients and recommended that the Task Force "review the variety of housing, social, medical, legal, crisis care, income and discharge issues affecting the well-being of discharged patients across the City and recommend a precise course of action to Council."

Further to Executive Reports Number 11 (February 9, 1983) and Number 22 (May 16, 1983), City Council adopted the terms of reference for the Task Force as follows:

> To investigate current studies and pertinent data, consult with all affected and interested parties, and report to City Council through the Executive Committee on means of achieving a continuity to programs and care for discharged patients in Toronto.
>
> In particular, to report to Council on the means of achieving resolution of the following matters in relation to the present and future well-being of discharged patients:
>
> - the current provision and anticipated need for an adequate supply and quality of residential settings for ex-patients, from high support to minimal supervision types;
> - the necessary degree of regulation of privately operated accommodation for ex-patients;

- the current and desired standard of public health, medical, social and recreational aftercare for ex-patients;
- the discharge policy of the Queen Street Mental Health Centre;
- Federal and Provincial government policy regarding the distribution through funding of group homes and other forms of housing for ex-patients across Metropolitan Toronto;
- the provision of adequate income support;
- the issue of legal and tenant rights; and
- the need for public education and sensitization to the ex-patient community.

1. INTRODUCTION

I accepted the Mayor's request to chair this Task Force because of his firm conviction that the City must play a meaningful role in dealing with the problems faced by discharged psychiatric patients. It also became clear to me that the majority of the members on City Council were also committed to finding a solution to these problems.

This has been the most challenging assignment of my life. My past experience in chairing or participating on government commissions or federal and provincial task forces in no way paralleled the complexity of the problems faced by this Task Force.

My experience in this field goes back 30 years, to my work with Dr. Clarence Hincks and Dr. J. D. Griffin, pioneers in the mental heath movement. As well, I worked on the famous Tydhurst report of 1952, which laid the groundwork for the process of deinstitutionalization. Neither my former colleagues or I ever fully appreciated the need for a comprehensive range of aftercare support services, including adequate housing. Without such a continuum of service, however, it has become impossible for many discharged psychiatric patients, particularly the chronically disadvantaged, to live with dignity in our communities. As we know, these communities have not always been friendly or accepting -- and some have even been hostile.

My task has often seemed overwhelming and demanding. I have given it all my energy, strength and whatever intellectual and imaginative gifts I may possess. My burden has been immeasurably lightened by the calibre of competence and sensitivity of my Task Force Coordinator, Marilou McPhedran, who has worked so closely with me. The cooperation of the "City Hall Folk", politicians and other officials, has been superb -- responding to all my requests. Professionals and other staff from agencies and organizations in the field, have all shared their studies, hopes, dreams and plans with me. Civil servants of all ranks from every Ministry have been helpful as well. Whatever has been accomplished has been through a team approach; concepts were moulded, hammered and fine-tuned by an army of helpers, especially my Advisory Committee, who were ever on call.

A great change in the last three decades has been the shift from "charitable" thinking to an appreciation of the social rights of human beings. However, we still seem to drag dinosaurs of the past on wheels into our present thinking.

We have too much evidence that the back wards of the former institutions have shifted to the community. In these former institutions, patients were too often out of sight and without a voice. Now, in the community they may still be invisible to many, but there are those among them who speak with great courage, though still some trepidation. The Pat Capponis of this city and a handful of other discharged psychiatric patients have worked diligently and zealously to make their plight known to the public.

The mandate as received by me was extraordinarily broad - the Task Force could have carried on for several years, written an encyclopedia and made a thousand recommendations. I have chosen to narrow my mandate, to focus our work on the chronically disadvantaged - that core of discharged psychiatric patients who suffer most and are in greatest need.

These are the people who live with fear and great courage - who spoke out with anxious voices at our public hearings to tell us of suicides; of the fear of being transferred in the night to a strange boarding home; of finding their meagre belongings on the sidewalk; of what it is to lack a decent income or live barely beyond the level of survival. They told us of being barred from hostels or living in fear in others; of being taken by police from one hospital to another during a crisis, without help forthcoming. They told us of where they live, of some fellow boarders who move like zombies, eating silently together and then returning to their boredom.

It's a long story, often unpleasant. It's a story of vulnerable, sensitive human beings without a feeling of value - so near the rock bottom of despair. It is these people, in this City, that this report addresses.

The number of chronically disadvantaged discharged psychiatric patients in Toronto is difficult to come by. Hard data are not available - the best calculated guess of the numbers in Toronto of this core group is around 1,800. The report strives not to pigeon-hole 1,800 human beings, but rather to develop a plan for finding solutions for these people based on an appreciation for their individual dignity. It has been my goal to find out how there can be better working mechanisms among the various levels of government so that human needs become the real determinant of policies. We must strive to develop means of meeting these needs rather than making people fit the needs of our bureaucracies, agencies and institutions.

The format of this report may seem cool, objective or academic to those people who are more comfortable with passionate expressions. Let me make it very clear to all who read this report that behind the words and statistics is a real, tough human problem, which dictates a sense of urgency to the deliberations that must follow from here. The problem will not go away - if this situation is allowed to deteriorate, the blemish becomes more difficult to eradicate.

The key proposals in this report are:

1) Housing with the full range of appropriate services is given the highest priority;

2) Hostels, police and cooperative housing groups have identified the need for support services not currently delivered by general hospitals. This led to my proposal for a range of crisis intervention services, including a short-term free-standing centre complementary to the extension of services delivered by general hospitals, emergency wards and community-based agencies.

3) One cannot help but be impressed and confused by the Metro District Health Council 1983 Inventory of Adult Mental Health Services, which catalogues over 300 pages of titles of services. Who are they? Whom do they help? And why do we still have so many gaps in service when there are so many service agencies? These are questions that immediately come to mind. The Parkdale Working Group (under the auspices of the Ministry of Health) has identified, after more than a year in operation, that coordination of services is a key problem. My experience would lead me to concur with this assessment. Good coordination will have to be City-wide and Metro-wide, with considerable provincial support. It should become the means whereby we avoid long term funneling and "ghettoizing" of any one area of this City. Such a coordinated plan can only come about by concerted and articulated political will from the City of Toronto, Metro Toronto, and the Province of Ontario. No one level of government can deal with this problem in isolation. I am convinced that the Provincial Cabinet as a whole must place a high priority on this particular group by designating a lead ministry and ensuring cooperation among the Ministries of Health, Municipal Affairs & Housing, Community & Social Services, and the Secretariat for Social Development. So too, the Toronto City Council should designate a lead Department and ensure cooperation among the Departments of Public Health, Planning & Development, Buildings & Inspections, Parks & Recreation, Legal and Fire. It will take supreme effort to smooth the vertical and horizontal mechanisms for action within and among levels of government, ministries and departments. The time for political scapegoating has passed. What we need now is the exercise of political will and action.

The public also has a responsibility. Politicians respond to the public will, and it is the public who will have to learn what being your brother's keeper in the 1980s really means. Caring is a noble art. It not only enriches the one who cares and gives with heart, mind and hand, but it also recognizes that the recipient must be the basic part of the equation: What does he or she want? Need? Feel? Care about? A sense of dignity is just as important to the one who receives as it is to the one who gives. The prevalent attitude of "not on my street" toward the emotionally disadvantaged has to be looked at and challenged. Without a change in public attitude, no humane, dignified solution is possible. There is a great need for dedicated groups - religious, volunteer, self-help. All will require public support to accomplish these ends. I am heartened by the efforts of many of these groups toward promoting community acceptance of supportive housing.

We who consider ourselves as civilized should pause and think for a moment. A great City such as ours is not to be judged only by its beautiful buildings, its clean streets, its subway system or its harbourfront. The true measure of a civilization rests upon how it cares for its vulnerable members.

Dr. Reva Gerstein, O.C., Psych.C.
February, 1984

2. RESPONSE TO THE PRELIMINARY REPORT

My Preliminary Report was released in November of 1983 and since then I have continued to meet with my Advisory Committee, members of Council, representatives from agencies, hospitals, the medical profession and departments and ministries of all three levels of government. As well, on November 30, 1983, the Task Force held a Public Hearing to receive response to the Preliminary Report. This meeting, held in the Council Chambers, was well-attended and over 20 deputations were heard. Commentary was thoughtful and constructive. Everything said to me since the Preliminary Report was released has been considered carefully and changes have been made to the text of my Final Report and Recommendations, although the substance of my original findings remains.

In the last chapter of this Final Report, I refer to the crucial role played by the media in shaping public attitudes. In their coverage of my Preliminary Report, members of the media have demonstrated responsible and highly professional interest in the issues raised. A brief description of the media response is contained in this chapter.

In keeping with the nature of the Task Force which has allowed my advisors and me to actively respond to events and problems which arose in the course of inquiry, I have tried to include in this Final Report research and commentary recently brought to my attention. A whole new chapter dealing with vocational rehabilitation (work) has been added. As well, I have had extensive discussions about the preliminary recommendations, in particular, those I made regarding group homes, the Contract Aftercare Project and a crisis intervention centre based in the community.

I am very concerned by the nature of resistance to the establishment of group homes in some parts of Metropolitan Toronto. The "not on my street" attitude, which I mention in my Introduction and discuss in the last chapter of this Final Report, seems to have resurfaced to an alarming degree at the recently convened Ontario Municipal Board Hearing on amendments to the Metroplan which reflect the provincial government's policy of encouragement to the establishment of group homes. In light of these events, I re-examined my recommendations on group homes and I strongly believe that they should remain the same.

With regard to the Contract Aftercare Project on boarding homes, changes have been made in order to clarify the intent of the preliminary recommendations. I am grateful to the officials and politicians at all three levels of government who took the time to assess the viability of this proposal. In this Final Report, I have recommended a more specific means of implementation: a structure which combines input from the City, Metro and the Province.

I have made numerous recommendations about the expansion of crisis intervention services. Representatives from community agencies such as the Supportive Housing Coalition and Houselink and from the Hospital Council of Metropolitan Toronto and the Association of General Hospital Psychiatric Services have contributed greatly to the refinement of my preliminary recommendations about crisis intervention.

I sense that the time is "ripe" in Metro Toronto for innovative and exciting "joint ventures" between hospitals and their communities in developing services for discharged psychiatric patients. For example, some such projects have already been developed out of Toronto East General Hospital and are briefly described in the Crisis Intervention chapter. The positive attitude reflected in a letter I received from Maxwell Goldhar, the Chairman of the Hospital Council of Metropolitan Toronto, is encouraging: "We look forward to your report serving as a catalyst for problem solving in this very important and difficult area. Please be assured of the support and assistance of HCMT in the follow-up and implementation of the recommendations." (January 23, 1984 correspondence from Maxwell Goldhar.)

My last reference is to governmental response. I have already remarked on the complexity of intergovernmental responsibilities for the delivery of services to discharged psychiatric patients in my Introduction. Throughout the past year, the primary goal of the Task Force has been to forge more effective linkages among the three levels of government and to reduce the extent to which discharged psychiatric patients become political footballs. To this end, I sought written commitment from key leaders at all three levels and I am delighted to be able to present them to you in this Final Report. Because the Province quite properly bears the primary responsibility for delivery of the needed services, I have presented the letter from Premier William Davis first, followed by the personal commitments of Metro Chairman Paul Godfrey and Mayor Arthur Eggleton. The Mayor has asked that I reconvene the Task Force in the fall of this year to evaluate progress made in regard to my final recommendations and I am pleased to agree to do so, having obtained the generous support of my Advisory Committee to assist me once again.

The Premier
of Ontario

Parliament Buildings
Queen's Park
Toronto, Ontario
M7A 1A1

965-9353

January 31, 1984

Reva

Dear ~~Dr.~~ Gerstein:

I was pleased to learn that you have completed the most important and challenging task given to you by the Mayor of the City of Toronto.

As you proceed to submit your final report, I want to take this opportunity to reaffirm the importance placed by the Government of Ontario on developing sensitive and humane solutions to the problems faced by discharged psychiatric patients, both in Toronto and elsewhere across the Province.

The final report of the task force contains many recommendations which relate to the Government of Ontario. I am confident that in the ongoing discussions which will flow both from your recommendations and from our own policy development process, the responsible Ministers and their officials will make every effort to adopt a coordinated and cooperative approach.

In partnership with the community and sensitive to concerns of everyone involved, I believe that Governments, along with religious and other volunteer groups can work together to meet our collective responsibilities in this important matter.

Best wishes.

Sincerely,

William G. Davis

The Municipality of
Metropolitan Toronto

Office of the Chairman
City Hall, 2nd Floor,
Toronto, Ontario, Canada M5H 2N1
Telephone: (416) 947-8001 Telex: 06-23472

Paul V. Godfrey, B.A.Sc., P.Eng.
Metropolitan Chairman

January 30, 1984

Dr. Reva Gerstein, O.C., Psych.C.,
Chairperson
Mayor's Action Task Force on
Discharged Psychiatric Patients
7th Floor, East Tower
City Hall
Toronto, Ontario
M5H 2N1

Dear Dr. Gerstein:

Allow me to congratulate you on the fine examination of a pressing social issue both in work carried out by your Task Force over the past year and in your Preliminary and Final Report.

I want you to know that I personally support the intent of the recommendations which you have made. Insofar as they pertain to the Municipality of Metropolitan Toronto, I will do whatever I can to assist in ensuring that Metro Council is able to deal expeditiously with them.

Sincerely,

Paul Godfrey

27/cd
56.1
13.1

The City of Toronto
Arthur C. Eggleton
Mayor

January 19, 1984

Dr. Reva Gerstein,
Mayor's Action Task Force
on Discharged Psychiatric Patients,
7th Floor, East Tower,
City Hall.

Dear Dr. Gerstein:

Further to our most recent discussion of January 18, 1984, I want to again express my sincere personal thanks to you and your Advisory Committee members for outstanding service to the Council and people of Toronto.

I do want to affirm my personal support for the direction you are taking in your work, and assure you that the implementation of our collective decisions having to do with discharged psychiatric patients in Toronto will remain foremost on my personal agenda.

As an additional matter, it seems to me that one proposal made to the Task Force at its public meeting of November 30, 1983 deserves our special attention. I understand that a proposal was put to reconvene the Task Force and Advisory Committee in the fall in order to review progress. I favour this idea, and I would appreciate your response to it.

Again, many thanks for your tireless help.

Sincerely,

Art Eggleton

AE:dg:bw

City Hall, Toronto M5H 2N2, Canada. (416) 947-7001

MEDIA RESPONSE TO THE TASK FORCE

TELEVISION:

	CFTO TV, program "Hour Long". Interview with Isabel Bassett and Dr. Gerstein about the Preliminary Report.
	TV ONTARIO, documentary program "People Patterns". Dr. Gerstein interviewed by Joan Reed-Olsen, on the current "happenings" in the Parkdale area.
News coverage November, 1983:	CBC, CITY and MTV. Covering the Preliminary Report.

RADIO:

December 9, 1983	CBC National Radio. Peter Gzowski interview with Dr. Gerstein on "Morningside" program.
January 11, 1984	CKFM Radio, noon hour program "Hour Toronto". Interview by Judy Webb on Dr. Gerstein's life-long involvement in the care of psychiatric patients.
News coverage, November, 1983	CKEY, CJCL, CFNY, CHFI, CBC Radio, CBC French Radio, CKO and CFMB, covering the Preliminary Report.

PRINT MEDIA:

February 13, 1983	TORONTO STAR. Editorial announcing the appointment of Dr. Reva Gerstein to the Task Force, commenting that ultimately, the responsibility of better housing for ex-psychiatric patients "rests squarely on the shoulders of Queen's Park."
February 28, 1983	TORONTO STAR. Reporter Susan Pigg interviewed Dr. Reva Gerstein on her appointment to chair

	the Task Force. In-depth look at Dr. Gerstein's involvement in the field, and feelings on the subject.
April 13, 1983	TORONTO STAR. Report on the decision of the first Advisory Committee meeting of Tuesday April 12, to meet in private. Dr. Gerstein is quoted briefly.
April 14, 1983	TORONTO, GLOBE AND MAIL. Jane Gadd reported on an interview with Pat Capponi, on the matter of the public being excluded from Task Force meetings.
April 18, 1983	TORONTO SUN. Reporter Ted Welch in column "At City Hall", with complaints that the Task Force meetings are to be in private.
April 19, 1983	GLOBE AND MAIL. Report on Mayor Eggleton's comments that members of City Council are welcome to attend the private meetings of the Task Force.
April 19, 1983	TORONTO SUN. Reporting that Mayor Eggleton is examining ways of opening the Task Force meetings to the public and that a report will be made to Council.
May 6, 1983	TORONTO STAR. Mayor Art Eggleton referred to the recently appointed Task Force, headed by Dr. Reva Gerstein, as taking a "good hard look" at the rooming house issue. On completion the Task Force would make recommendations for solving the problem.
May 18, 1983	TORONTO STAR. Reporter Susan Pigg on the first public meeting of the Advisory Committee, May 17, 1983. Commissioner George C. Cook spoke on the survey of 10 rooming houses showing that most could barely pass City building code standards.

June 14, 1983	TORONTO STAR. Susan Pigg reported on Constable Michael Fredrico's presentation to the Advisory Committee meeting of the Task Force on Tuesday June 14, 1983. Constable Fredrico suggested that a "home assessment team" made up of mental health experts should be available 24 hours a day to assist police.
November 24, 1983	TORONTO STAR. Reporter Susan Pigg covering the Press Conference in which the Mayor and Dr. Gerstein announced the recommendations outlined in the Preliminary Report.
November 24, 1983	TORONTO SUN. Reporter Ian Harvey with coverage of Press Conference to introduce the Preliminary Report.
November 25, 1983	GLOBE & MAIL. Comments on the Preliminary Report of the Task Force.
December 1, 1983	GLOBE & MAIL. Reporter Jock Ferguson covering the Public Meeting of the Task Force held November 30, 1983.
December 1, 1983	TORONTO SUN. Report of the Task Force's Public Meeting of November 30, 1983.
December 4, 1983	TORONTO STAR. Susan Pigg interview with Dr. Gerstein.
December 8, 1983	TORONTO STAR. Susan Pigg reporting on interview with Ald. Korwin-Kuczynski, with comments on the Preliminary Report of the Task Force.
December 9, 1983	TORONTO STAR. Special reporter S. G. Perry, "Insight" column on everyday lives of Toronto's ex-psychiatric patients, with mention of the Task Force.

PRESS CONFERENCES

February 9, 1983	Press Conference held by Mayor Arthur Eggleton to anounce the Task Force and to introduce Dr. Reva Gerstein.
November 23, 1983	Press Conference held by Mayor Arthur Eggleton and Dr. Reva Gerstein, announcing the completion of the Preliminary Report and Notice of the Public Meeting of November 30, 1983. Most television and radio stations, and newspapers were represented.

3. SUMMARY OF RECOMMENDATIONS

Chapter 6: Housing

GROUP HOMES

RECOMMENDATION #1: THAT THE COUNCIL OF THE CITY OF TORONTO RE-AFFIRM ITS SUPPORT IN PRINCIPLE FOR GROUP HOMES AS A NECESSARY COMPONENT IN THE RANGE OF SUPPORTIVE HOUSING FOR DISCHARGED PSYCHIATRIC PATIENTS.

RECOMMENDATION #2: THAT THE COUNCILS OF METROPOLITAN TORONTO AND THE CITY OF TORONTO DEMONSTRATE THEIR COMMITMENT TO THE SOCIAL BENEFITS OF GROUP HOMES BY MAKING AVAILABLE AT A NOMINAL COST ONE HOUSE EACH WHICH IS SUITABLE FOR IMMEDIATE USE AS A NON-PROFIT GROUP HOME FOR DISCHARGED PSYCHIATRIC PATIENTS. THAT THE APPROPRIATE METRO AND CITY STAFF REPORT, IN CONSULTATION WITH THE SUPPORTIVE HOUSING COALITION, ON THE LOCATION, REPAIR AND OPERATION OF EACH SUCH HOME IN ORDER THAT THEY BE IN OPERATION BY THE FALL OF 1984.

BOARDING HOMES

RECOMMENDATION #3: THAT THE PROVINCE OF ONTARIO IN COOPERATION WITH THE CITY OF TORONTO DEVELOP AND PUT IN PLACE THE CONTRACT AFTERCARE PROJECT, (C.A.P.) TO COMPRISE THE FOLLOWING COMPONENTS:

1) AN AGREEMENT BETWEEN THE PROVINCE OF ONTARIO AND THE CITY OF TORONTO BY WHICH THE PROVINCE PROVIDES FINANCIAL RESOURCES FOR THE REPAIR AND REHABILITATION OF 10 EXISTING BOARDING HOUSES IN THE CITY OF TORONTO, BEGINNING IN THE PARKDALE NEIGHBOURHOOD, IN EXCHANGE FOR THE CITY'S UNDERTAKING TO IMPLEMENT, ADMINISTER AND MONITOR THE C.A.P.

2) HAVING RECEIVED THE FUNDS FROM THE PROVINCE, THE CITY WILL IN TURN ALLOCATE THESE PROVINCIAL FUNDS BY MEANS OF AN AGREEMENT WITH THE OWNER/OPERATOR OF AN EXISTING BOARDING HOUSE FOR REHABILITATION AND REPAIR OF THE PROPERTY IN EXCHANGE FOR:

   i) COMPLIANCE WITH PHYSICAL STANDARDS SPECIFIED IN A CONTRACT (SEE SCHEDULE A OF THE DRAFT PROTOTYPE CONTRACT IN APPENDIX A);

   ii) THE PROVISION BY THE OWNER/OPERATOR OF SERVICES THAT MEET STANDARDS SPECIFIED IN THE CONTRACT (SEE

SCHEDULE B OF THE DRAFT PROTOTYPE CONTRACT IN APPENDIX A);

iii) AN UNDERTAKING GIVEN BY THE OWNER/OPERATOR OF THE PROPERTY IN QUESTION TO ENSURE ACCESS TO THE PREMISES BY A SERVICE AGENCY WHICH IS RECOGNIZED AND APPROVED BY THE IMPLEMENTATION COMMITTEE AND IS IN RECEIPT OF FUNDING FOR THE PROVISION OF AFTERCARE PROGRAMS TO RESIDENTS WHO CHOOSE TO RECEIVE SUCH SERVICES ON THE PREMISES IN QUESTION.

RECOMMENDATION #4: THAT THE C.A.P. BE ADMINISTERED BY AN IMPLEMENTATION COMMITTEE, WHOSE MEMBERSHIP WILL INCLUDE: THE CURRENT MEMBERS OF THE ALTERNATIVE HOUSING SUB-COMMITTEE OF THE NEIGHBOURHOODS COMMITTEE OF TORONTO CITY COUNCIL; ONE STAFF REPRESENTATIVE EACH FROM THE ONTARIO AND METROPOLITAN TORONTO GOVERNMENTS; A REPRESENTATIVE OF THE MEDICAL OFFICER OF HEALTH, AND THE COMMISSIONER OF BUILDINGS AND INSPECTIONS.

RECOMMENDATION #5: THAT THE RESPONSIBILITIES OF THE IMPLEMENTATION COMMITTEE COMMENCE IMMEDIATELY AND INCLUDE:

a) DEVELOPMENT OF A HIGH QUALITY INTERIM RESIDENTIAL FACILITY TO BE PUT IN PLACE PRIOR TO THE REPAIR OF ANY CONTRACT HOUSE TO BE AVAILABLE TO TENANTS WHO MAY BE DISPLACED DURING REPAIRS;

b) SELECTION BY PROPOSAL CALL AND IN CONSULTATION WITH THE APPROPRIATE WARD ALDERMEN OF THE CONTRACT HOUSES FOR THE PROJECT;

c) THE ADMINISTRATION OF THE CONTRACTS AND AGREEMENTS REFERRED TO IN RECOMMENDATION 3 AND THE IDENTIFICATION AND DIRECTION OF CITY STAFF TO CARRY OUT THE INSPECTION AND MONITORING OF THE CONTRACT HOUSES;

d) CONDUCTING ANNUAL REVIEWS AND RECOMMENDING APPROPRIATE CONTRACT RENEWALS TO CITY COUNCIL;

e) ENSURING THAT PRIORITY OF TENANCY IN THE UPGRADED CONTRACT HOUSES BE GIVEN TO THOSE WHO RESIDED IN THE HOUSE AT THE TIME THE CONTRACT WITH THE CITY WAS SIGNED.

RECOMMENDATION #6: THAT THE CITY SOLICITOR BE REQUESTED TO PREPARE DRAFT LEGISLATION AS NECESSARY TO ENABLE THE CITY'S PARTICIPATION IN THE C.A.P. BASED ON THE PROPOSALS SET OUT IN THIS REPORT FOR SUBMISSION TO THE CURRENT (SPRING SESSION) OF THE ONTARIO LEGISLATURE.

LEGAL STATUS OF TENANTS

RECOMMENDATION #7: THAT THE MINISTER OF CONSUMER AND COMMERCIAL RELATIONS BE REQUESTED TO REVIEW APPENDIX C OF THIS REPORT AND TAKE STEPS TO AMEND THE LANDLORD AND TENANT ACT SO THAT IT IS CLEAR THAT ITS PROVISIONS APPLY TO OCCUPANTS OF ROOMING AND BOARDING HOUSES.

RECOMMENDATION #8: THAT THE MINISTER OF CONSUMER AND COMMERCIAL RELATIONS BE REQUESTED TO DEVELOP PROVISIONS IN THE LANDLORD AND TENANT ACT TO DEAL WITH PROBLEMS UNIQUE TO ROOMING AND BOARDING HOUSES AS DETAILED IN APPENDIX C OF THIS REPORT, AND TO ADVISE CITY OF TORONTO COUNCIL ON HIS CONSIDERATION OF THIS MATTER BY SEPTEMBER, 1984.

RECOMMENDATION #9: THAT THE CABINET OF THE GOVERNMENT OF ONTARIO UNDERTAKE THROUGH THE ESTABLISHMENT OF AN INTERMINISTERIAL COMMITTEE, A REVIEW OF THE LEGAL STATUS OF TENANTS IN THE SUPPORTIVE HOUSING SECTOR. THIS REVIEW SHOULD BE DONE IN CONSULTATION WITH DISCHARGED PSYCHIATRIC PATIENTS, COMMUNITY WORKERS AND OTHER SERVICE PROVIDERS ABLE TO PROVIDE THE INTERMINISTERIAL COMMITTEE WITH ESSENTIAL PRACTICAL KNOWLEDGE NOT OTHERWISE AVAILABLE, WITH A VIEW TO ENSURING THAT THESE TENANTS ARE AFFORDED APPROPRIATE PROTECTION COMMENSURATE WITH THE UNIQUE AGENCY/RESIDENT RELATIONSHIP IN SUPPORTIVE HOUSING.

Chapter 7: Crisis Intervention Services

RECOMMENDATION #10: THAT THE GENERAL HOSPITALS IN THE CITY OF TORONTO SERIOUSLY CONSIDER THE ESTABLISHMENT OF CRISIS INTERVENTION TEAMS BASED ON THE MODELS THAT HAVE BEEN DEVELOPED AT THE MISSISSAUGA HOSPITAL AND THE TORONTO EAST GENERAL.

RECOMMENDATION #11: THAT THE MINISTRY OF HEALTH DEVELOP WAYS TO INCREASE FUNDING FOR EXTENSION OF HOURS AT AFTERCARE SERVICES USED BY DISCHARGED PSYCHIATRIC PATIENTS IN CRISIS, SUCH AS THE SATELLITE CLINICS OF THE QUEEN STREET MENTAL HEALTH CENTRE, THE PARKDALE ACTIVITY AND RECREATION CENTRE AND SOME PROGRAMS RUN BY SELF-HELP GROUPS.

RECOMMENDATION #12: THAT THE HOSPITAL COUNCIL OF METROPOLITAN TORONTO UNDERTAKE TO DEVELOP PROPOSALS BY THE FALL OF 1984 TO PROMOTE JOINT VENTURES BETWEEN GENERAL HOSPITALS AND COMMUNITIES TO SERVE CHRONIC PSYCHIATRICALLY DISABLED PEOPLE.

RECOMMENDATION #13: THAT A TORONTO COMMUNITY CRISIS CENTRE BE SET UP ALONG THE FOLLOWING LINES:

1) IN GENERAL, LENGTH OF STAY TO BE FEWER THAN 7 DAYS. THE OBJECTIVE IS TO HELP A PERSON IN PSYCHIATRIC CRISIS TO BECOME STABILIZED SUFFICIENTLY TO RETURN TO THE COMMUNITY WITHOUT INAPPROPRIATE HOSPITALIZATION. METHODS WILL INCLUDE SHORT-

TERM SUPPORTIVE COUNSELLING; EFFECTIVE REFERRAL LINKS; CONCRETE ASSISTANCE WITH IMMEDIATE CRISIS RELATED PROBLEMS; ACCESS TO SELF-HELP SUPPORT OR COUNSELLING WHERE APPROPRIATE; MEDICATION WHERE APPROPRIATE. METHODS WILL NOT INCLUDE FORCED MEDICATION. THE EXPECTATION IS OF A SPEEDY RETURN TO THE COMMUNITY.

2) THE TARGET CLIENTS ARE CHRONIC PSYCHIATRICALLY DISABLED ADULTS IN CRISIS WHO LACK SUPPORTIVE RESOURCES. THE CENTRE IS NOT DESIGNED FOR INVOLUNTARY CLIENTS. INITIALLY IT IS ANTICIPATED THAT WITHIN THESE PARAMETERS ADMISSION CRITERIA MUST BE FLEXIBLE. THE CENTRE SHOULD STRIVE TO AVOID A TOO RESTRICTIVE APPLICATION OF "CHRONIC PSYCHIATRICALLY DISABLED". AT THE SAME TIME, THE TARGET IS THE PATIENTS WITH PSYCHIATRIC CRISES OF A CHRONIC NATURE - THOSE WHOSE NEEDS ARE DEMONSTRABLY NEGLECTED - AND THE ORIGINAL MANDATE SHOULD NOT BE DILUTED.

3) A FREE-STANDING CENTRE LOCATED IN A HOUSE-FORM SETTING IN DOWNTOWN TORONTO.

4) NO MORE THAN FIFTEEN BEDS BE AVAILABLE IN A COMFORTABLE, NON-INSTITUTIONAL ENVIRONMENT. THERE IS RESEARCH AVAILABLE TO SUGGEST THAT THE IDEAL NUMBER OF RESIDENTS IN A CRISIS SETTING MAY BE SIX TO TEN. (MOSHER AND MENN, 1979).

5) THE HOURS OF OPERATION BE 7 DAYS PER WEEK 24 HOURS PER DAY, HOLIDAYS AND WEEKENDS INCLUDED.

6) FUNDING FROM MINISTRY OF HEALTH, COMMUNITY HEALTH PROGRAMS BRANCH. ESTIMATED START-UP COSTS $644,800. ANNUAL COST $500,000. (SEE APPENDIX E)

7) CRISIS CENTRE TO BE OPERATED AND MANAGED BY A COMMUNITY BOARD RESPONSIBLE TO THE CITY OF TORONTO AND THE MINISTRY OF HEALTH. PREDECESSOR TO THIS BOARD SHOULD BE A GROUP CONSIDERING THE DETAILS OF IMPLEMENTATION. THE MINISTRY AND THE CITY SHOULD APPOINT THIS PLANNING GROUP AS SOON AS POSSIBLE AND MEMBERSHIP SHOULD INCLUDE LOCAL RESIDENTS, SERVICE CONSUMERS AND MEMBERS OF THE SUPPORTIVE HOUSING COALITION SUB-COMMITTEE ON CRISIS CARE. THE EVENTUAL BOARD SHOULD INCLUDE A REPRESENTATIVE FROM THE GENERAL HOSPITALS.

8) MANDATE BE REVIEWED AFTER THREE YEARS OF OPERATION. EVALUATION TO BE BASED ON THE NUMBER OF CLIENTS SERVED, ENDORSEMENT FROM PSYCHIATRIC AFTERCARE PROVIDERS AND CONSUMERS, STAFF ASSESSMENT, BOARD.

9) QUALITY OF STAFF CRITICAL TO EFFECTIVE OPERATION. CENTRE STAFF TO INCLUDE MEDICALLY TRAINED AND COMMUNITY TRAINED MENTAL HEALTH CARE WORKERS. MODIFYING THE VANCOUVER VENTURE HOUSE MODEL:

1 COORDINATOR/DIRECTOR.
6 CLINICAL STAFF (REGISTERED NURSES, REGISTERED PSYCHIATRIC NURSES, PUBLIC HEALTH NURSES, OR PSYCHIATRIC SOCIAL WORKERS.)
6 COMMUNITY MENTAL HEALTH CARE WORKERS.
1 COOK.
1 SECRETARY.
PLUS RELIEF STAFF. 3 STAFF ON DUTY AT ALL TIMES.

10) ONE PSYCHIATRIST ON CALL AT ALL TIMES FOR MEDICAL EMERGENCIES, POSSIBLE ADMISSION TO HOSPITAL, AND PRESCRIPTION OF MEDICATION.

11) STRONG LINKS BE FORGED WITH THE GENERAL HOSPITALS' EMERGENCY DEPARTMENTS AND PSYCHIATRIC WARDS AS WELL AS CASE MANAGERS. CENTRE IS INTENDED TO BE FREE-STANDING, AN ALTERNATIVE STEP BUT NOT ISOLATED FROM HOSPITAL OR COMMUNITY.

12) EFFECTIVE REFERRAL LINKS BE ESTABLISHED AND MAINTAINED TO AND FROM COMMUNITY SERVICES. A CENTRAL OBJECTIVE IN EARLY STAGES OF THE PROGRAM TO BE LIAISON WITH POTENTIAL USERS OF THE SERVICE - HOSTELS, CONSUMER GROUPS, POLICE, BOARDING HOME OPERATORS AND FAMILIES.

13) PART OF PRELIMINARY PROCESS TO INCLUDE EXTENSIVE TRAINING FOR STAFF WITH A VIEW TO GAINING AWARENESS OF SERVICES AVAILABLE AS DETAILED IN DISTRICT HEALTH COUNCIL INVENTORY OF MENTAL HEALTH SERVICES IN METRO. SIMILARLY, A VITAL EARLY TASK IS FOR CRISIS CENTRE STAFF TO EDUCATE SERVICE PROVIDERS AND COMMUNITY RESOURCE GROUPS ON THE CENTRE'S ROLE.

14) FROM THE INCEPTION OF THE PROGRAM A LEASED CAR AND AT LEAST ONE STAFF MEMBER BE AVAILABLE FOR MOBILE COMMUNITY PROBLEM INTERVENTION. AS THE NEED IS REVIEWED, THIS MOBILE RESPONSE UNIT COULD PLAY AN INCREASING ROLE IN THE PROVISION OF EMERGENCY SERVICES AND MAY LINK UP TO THE METRO AMBULANCE/POLICE SYSTEMS.

15) IN THE SECOND YEAR OF OPERATION, A DISTRESS LINE BE ADDED TO THE SERVICE. INITIALLY, THE 911 EMERGENCY NUMBER FOR REFERRALS SHOULD BE ENCOURAGED. THE "HOTLINE" SEEMS PARTICULARLY VALUABLE IN VIEW OF THE VANCOUVER EXPERIENCE WHERE MANY PROBLEMS THAT CAN TURN INTO EMERGENCIES - FOR EXAMPLE, UNCERTAINTY ABOUT MEDICATION - CAN BE FORESTALLED ON THE PHONE. LIAISON WITH GENERAL DISTRESS LINES NOW IN OPERATION SHOULD FIRST BE UNDERTAKEN.

Chapter 8: Work.

RECOMMENDATION #14: THAT THE CABINET OF THE GOVERNMENT OF ONTARIO ESTABLISH AN INTERMINISTERIAL COMMITTEE AT THE SENIOR LEVEL TO

COORDINATE PROVINCIAL ACTIONS, AND TO PROMOTE COOPERATION BETWEEN THE PROVINCIAL AND FEDERAL GOVERNMENTS IN VOCATIONAL REHABILITATION PROGRAM DEVELOPMENT.

RECOMMENDATION #15: THAT THE INTERMINISTERIAL COMMITTEE, AS ONE OF ITS FIRST ACTIONS, COMMISSION AN INDEPENDENTLY-CONDUCTED STUDY OF EMPLOYMENT NEEDS AND OPPORTUNITIES OF THE PSYCHIATRICALLY DISABLED IN ORDER TO DEVELOP A PRACTICAL MODEL FOR A CONTINUUM OF SERVICES IN THIS FIELD.

RECOMMENDATION #16: THAT THE INTERMINISTERIAL COMMITTEE AND THE EQUAL OPPORTUNITY PROGRAM OFFICES OF METROPOLITAN TORONTO AND THE CITY OF TORONTO REVIEW THEIR RESPECTIVE PERSONNEL POLICIES TO PUT IN PLACE MECHANISMS THAT WILL ACCELERATE HIRING OF THE PSYCHIATRICALLY DISABLED IN THE PUBLIC AND PRIVATE SECTORS.

RECOMMENDATION #17: THAT THE MINISTRY OF COMMUNITY AND SOCIAL SERVICES REDEFINE "EMPLOYMENT" TO INCLUDE PART-TIME FLEXIBLE WORK ON AN EQUAL BASIS WITH FULL-TIME PERMANENT WORK.

Chapter 9: Coordination of Aftercare Services.

RECOMMENDATION #18: THE MINISTRY OF HEALTH SHOULD COMMISSION AN INDEPENDENT RESEARCH PROJECT INTO THE USE OF MEDICATION TO MAINTAIN PATIENTS IN THE COMMUNITY. RESEARCH CONCERNS SHOULD INCLUDE THE APPROPRIATENESS OF SUCH MEDICATION; EFFECTS ON FUNCTIONING; POSSIBLE SIDE EFFECTS; THE INFORMATION PROVIDED TO THE USERS; AND THE SYSTEM OF MONITORING LONG-TERM EFFECTS.

RECOMMENDATION #19: ALL PROFESSIONALS CONCERNED WITH AFTERCARE SERVICE DELIVERY - PHARMACISTS, PSYCHIATRISTS, GENERAL PHYSICIANS, CASE WORKERS AND OTHERS - SHOULD REVIEW THEIR POLICIES AND PROCEDURES AS REGARDS THE MONITORING OF PATIENTS' FUNCTIONING ON LONG-TERM PSYCHIATRIC MEDICATION. PROFESSIONAL ASSOCIATIONS SHOULD CONSIDER SUCH QUESTIONS AS ONGOING MEDICAL EDUCATION, THE NECESSITY FOR PROVIDING INFORMATION TO PATIENTS, AND THE POSSIBILITY OF A SYSTEM OF PEER REVIEW.

RECOMMENDATION #20: THAT THE MENTAL HEALTH PROGRAM PLACEMENT SERVICE BE ENDORSED IN PRINCIPLE BY THE CITY OF TORONTO, AND THAT COUNCIL REQUEST THAT THE INITIAL STAGE OF THE SERVICE MUST BE THAT OF EXTENSIVE CONSULTATION WITH THE AGENCIES, INCLUDING HOSPITALS AND THE QUEEN STREET MENTAL HEALTH CENTRE, WITH A PARTICULAR EMPHASIS BEING PLACED ON CONSULTING WITH CONSUMERS OF MENTAL HEALTH SERVICES IN THE PARKDALE AREA.

RECOMMENDATION #21: THAT CITY COUNCIL AND THE LOCAL BOARD OF HEALTH DEVELOP THE MEANS BY WHICH THE CITY OF TORONTO COULD "TWIN" WITH THE CITY OF ROME, ITALY, IN THE AREA OF SERVICES TO DISCHARGED PSYCHIATRIC PATIENTS.

4. THE HISTORICAL CONTEXT: PERSPECTIVES ON MENTAL HEALTH AND ILLNESS

In Canada, as elsewhere, the dilemma of how best to care for the chronic mentally ill person* has a lengthy history. Over the course of centuries, passionate advocates have proposed as well as practised reforms that seemed radical in their day, but are now dismissed as barbaric. Changing concepts of madness and ideas about appropriate treatment for it reflect broad cultural, political and economic biases. Despite the fact that proposed "solutions" have undergone dramatic changes throughout the years, the dilemma of how best to care for the chronic mentally ill stubbornly persists. Typically, the chronic mental patient has been the one to fall through the service gap created when performance has not lived up to promise in the psychiatric field. The fault was rarely in the reformer's intention. The concerned citizens, professionals and mental health service consumers of the 1980s, as were their predecessors, are motivated by a profound awareness of the problems and a desire to find solutions. It is rather humbling to examine the record of experimentation in this area; nonetheless, it is useful to take a second look before proceeding with proposals.

What began approximately 20 years ago as enthusiasm for the idea of discharging people with chronic psychiatric illnesses from mental institutions into the community has evolved into sober reappraisal of the often tragic consequences of inadequate follow-through with these people.[2] The policy of "deinstitutionalization" has too often been accompanied by a serious lack of the community resources needed to replace institutional care. The lives of those now subsisting in Toronto's transient hostels and boarding homes document this failure in planning, and will be addressed in the following sections of the Report. It is worth taking a moment to examine the roots of the concerns that led to this Task Force in order to provide a context for the Report.

* We have defined for the purposes of this report the chronic mentally ill person as "an adult who has persistent disabilities associated with a major psychiatric disorder".[1]

In Western feudal society, the non-disruptive mentally ill were cared for in the community, primarily by family and religious institutions. Madness was considered a form of demonic possession, sometimes calling for exorcism or death. But with the decline of church influence, secular views took hold. During the 16th and 17th centuries, the insane were seen as threats to society, along with cripples, the poor, and other "deviants".

The accepted solution for dealing with these people was to lock them away, often in chains. Humane concerns surfaced as part of the Enlightenment in the 18th century, and mental health pioneers (such as Pinel in France, and Tuke in Great Britain), tried to develop institutions designed specifically to care for the mentally disabled. Their successes inspired 19th century reformers in Europe and North America to call for the construction of publicly supported asylums. American crusader Dorothea Dix promoted the idea of "moral treatment", a belief that humane surroundings and staff could cure mental illness. Earlier, Ontario (then Upper Canada) had opened its first asylum in Toronto (then York), by converting a former jail. The Canadian provinces were handed responsibility for the care of the mentally ill at the time of Confederation in 1867.

By the early 20th century, appalling conditions in many of the mental institutions ("snake-pits") again produced calls for reform. Canada was caught up in the general North American awareness of mental health issues such as custody versus caring. Especially influential was the publication in the early 1900s of Clifford Beers' book, A Mind That Found Itself. A recovered patient, Beers exposed the horrendous conditions inside the mental institutions where he had been confined. At the same time, Adolf Meyer was espousing a familiar sounding public health program emphasizing the contribution of the social environment to mental illness, and its championing of a coordinated program of prevention, treatment and aftercare. Together, Meyer and Beers initiated the Committee for Mental Hygiene (a forerunner of the community mental health movement).

In Canada, Dr. Clarence Hincks, founder of the Canadian Mental Health Association (1918), travelled from one end of the country to the other, documenting the deficiencies in mental health care. During World War Two, the high rates of mental illness detected by Canadian Armed Forces screening procedures led to public awareness of the prevalence of mental illness in the population at large. After the war, the Federal Government took steps to upgrade the mental institutions, and from 1949 to 1959 there was an increase of almost 18,000 in bed capacity.

But in the 1960s, two major developments hastened the acceptance of the idea of community mental health. First, information became available from government reports and social/scientific studies that documented the failure of large institutions to cure mental illness. Some authors (for example, Erving Goffman) suggested that incarceration in hospital made matters much worse for the patient.

Second, the discovery of psychotropic drugs raised the hope that properly medicated patients could be stabilized and released into the community. The introduction of Canada's comprehensive medicare program in the late 1960s further supported the reasoning that appropriate care could be made available outside institutions. As a result, the idea of community mental health flourished.

Although support mechanisms for ex-patients in the community grew at a very slow pace, the discharge of patients from the institutions accelerated. From 1965 to 1976, the total number of patients in Ontario mental hospitals dropped by 75%. However, admission rates doubled, and discharges almost tripled. Re-admissions constituted two-thirds of all admissions. At least in theory, the approach in Ontario was to integrate psychiatric services with public health services. Part of the plan was to establish psychiatric units in the general hospitals, complemented by a variety of out-patient clinics. But, as will be evident in greater detail in the next section, the gap between theory and practice in deinstitutionalization experiments was great. Resources in the community were under-funded and sometimes non-existent. Once again, cries for reform were heard.

When it became clear that deinstitutionalization had not delivered all it had promised, disillusionment set in. Advocates from the community mental health movement had based their reforms on certain operating assumptions, and the validity of these assumptions now came under attack. Illustrative of this trend - which began in the U.S. - was a 1978 article in "Scientific American" that posed the question: "Does deinstitutionalization represent an enlightened revolution or an abdication of responsibility?" In their examination of "how such a well-intentioned reform as deinstutionalization could have created so many problems", the authors called attention to the fact that people with chronic psychiatric disabilities were being neglected. This theme has been taken up by many other observers - by those who attack the community model as simplistic, and by those who defend it as an imperfect version of worthwhile objectives. John Talbott, for example, is a staunch defender of the community model, based on his comparative studies that show that patients provided with adequate aftercare in the community fare better in a number of ways than those treated in hospital.. However, Talbott agrees that one result of deinstitutionalization was that "often the sickest patients were not receiving their share of attention". Nonetheless, Talbott and others warn against the "throwing the baby out with the bath water" phenomenon: He suggests that more community resources and better integration of service might provide further solutions.

In the same vein, but on a more pessimistic note, are two recent reports: 1) Community Psychiatry: A Reappraisal by the prestigious Group for the Advancement of Psychiatry, and 2) Caring for Mentally Ill People, a recent book by Alexander Leighton. Dr. Leighton, now Professor of Psychiatry and Preventive Medicine at Dalhousie University, identifies what he calls four barriers to effective mental health care:

1. "Heterogeneity of the field is not appreciated by many of the protagonists." In other words, use of the term "mental illness" disguises the diversity of the population.

2. "The emotions generated by the topic of mental illness tend to confuse most issues." Most observers feel dread and awe.

3. "There is a failure to stick to scientific procedures and facts as the basis for action." Political rhetoric is substituted for 'scientific' evaluation of outcomes.

4. "Too many goals and too few priorities continue to be articulated." From prevention, to public education, to care for the chronically ill - these comprehensive goals may defeat the achievement of even limited goals.

Dr. Leighton, formerly a leading proponent of community psychiatry, grounds his disillusionment on the experience of 21 years of overseeing (from a distance) a rural community mental health centre in Nova Scotia. In particular, he challenges commonly used, but rarely defined, terms such as "mental illness", "mental health", and "community". He argues that many of the problems arising from the movement toward providing mental health care in the community result from the fact that it is difficult to plan good care when the assumptions we are operating on are undefined, and possibly undefinable. He draws a critical distinction: "policies in mental illness care, like other policies, are determined by opinion, whereas outcomes are determined by realities. The challenge is to find ways and means for bringing opinions and realities closer together." Like Leighton, the Group for the Advancement of Psychiatry (G.A.P.) voices concern over the current outcome of the community psychiatry movement. In their report on community psychiatry, G.A.P. identifies nine major assumptions behind the community mental health movement:

1. Care in the community is less expensive than care in hospital.

2. Care in the community is better than care in hospital.

3. Comprehensive care is desirable and a necessary goal that can be achieved in the community.

4. Continuity of care is beneficial.

5. Designation of catchment areas enhances provision of services.
6. Accessibility to mental health services is essential.
7. Social environment produces mental illness.
8. Preventive efforts can reduce the incidence and prevalence of mental illnesses.
9. Local responsibility and control are necessary to ensure the success of community mental health.

Leighton, whose views are almost identical to those of G.A.P., questions these assumptions and concludes that psychiatry in general and the community mental health movement in particular, suffers from not having "an adequate, generally accepted frame of reference for dealing with mental illnesses".

In Canada, the Clarke Institute of Psychiatry Consulting Group provides a noteworthy exception to some of the criticisms raised by Dr. Leighton. In two studies, "Psychiatric Aftercare in Metropolitan Toronto" and the "Southern Alberta Study of Psychiatric Needs and Provisions," the consulting group manages to combine a concern for urgent problems with an awareness of theory and methods. It is certainly incorrect to say that serious research and evaluation are not taking place on the practise of community mental health care. For example, the Greater Vancouver Mental Health Services Evaluation and Research Department is collaborating with the Department of Psychiatry at the University of British Columbia and the University of Oregon at Portland, Oregon, in a study on the impact of different community aftercare treatment systems on patient outcome. The Vancouver model, which will be discussed further in the next section of this report, has an extensive system of aftercare services. This coordinated service model is compared to the system in Portland, Oregon, where there is virtually no aftercare available. The latter city serves as a "no treatment" locus of the study. Preliminary results show that the Vancouver patients who were followed after discharge from hospital had fewer hospitalizations following discharge and were more likely to be gainfully employed in the competitive market and leading fairly normal lives.[3]

While it is essential to address the valid points raised by critics of community mental health as it has developed, attention must be paid to those people who continue to work to improve the community mental health care delivery. Dr. John Wing, a prominent English psychiatrist, leaves us with this thought: "The idea, the vision, of 'community care' is not enough. It must be backed by hard, realistic planning and adequate resources. The vision can still be realized".

FOOTNOTES:

1. Clarke Institute of Psychiatry Consulting Group. Consultation Report: Systems Coordination for Psychiatric Services in Toronto, June 7, 1983.

2. This account is based on the following sources:

   Ellen Bassuk & Samuel Gerson, "Deinstitutionalization and Mental Health Services", Scientific American, February, 1978.

   Consulting Group, Clarke Institute of Psychiatry, extract from the "Southern Alberta Study of Psychiatric Needs and Provisions", Part 2, Current Concepts in Psychiatric Care: The Theoretical Basis of Our Recommendations. January, 1983.

   M. J. Dear & S. M. Taylor, not on our street, Pion Limited, 1982.

   Group for the Advancement of Psychiatry, Committee on Psychiatry and Community. Community Psychiatry: A Reappraisal, Mental Health Materials Centre, 1983.

   Charles Kiesler, "Public and Professional Myths About Mental Hospitalization", American Psychologist, December, 1982.

   Alexander H. Leighton, Caring for Mentally Ill People, Cambridge University Press, 1982.

   Steve Lurie, "More for the Mind, Have We Got Less?" November, 1980.

   Queen Street Mental Health Centre Symposium on the Organization and Delivery of Mental Health Services. May 25, 1983.

      C. A. Roberts, "More For The Mind Twenty Years Later, The Canadian Experience".

      J. A. Talbott, "Trends In The Delivery Of Psychiatric Services".

      John K. Wing. "Community Care: Vision, Theory and Practice".

3. Greater Vancouver Mental Health Service, 1982 Annual Report, p. 10-11. And personal communication with Ron Peters, GVMHS, Department of Evaluation and Research.

5. THE TORONTO SITUATION - A REVIEW OF THE LITERATURE

It should be noted that there was no financial allowance in the Task Force's budget for commissioning research. We proceeded on the understanding that not only had considerable research already been done, but that research was ongoing due to efforts by the Ministry of Health, the Metro District Health Council, and the City of Toronto Department of Public Health. For these reasons, the overview in this chapter represents an examination of the facts and proposals found in the articles and reports (referenced at the end of this chapter), as well as information presented at our public hearings. From this examination process a picture emerges of the present status of community mental health care in Toronto. The challenge for us is to determine how we can effectively improve the situation for the estimated 1,800 chronically disadvantaged discharged psychiatric patients who are living in Toronto and who are the focus of this report.

Part of the answer could be found in the more equitable distribution of financial resources. In 1983, $3.6 billion, or 53% of the total $6.8 billion provincial health care budget, was spent on the hospital sector. Only 3.3% of the total budget was allocated for community health services. (Remarks by The Honourable Larry Grossman, 1983.) However, as will become evident from this report, targeting more money to this particular aspect of mental health care offers only a partial solution to the complex problems of discharged psychiatric patients and their reintegration into the community.

Deinstitutionalization

As discussed in the previous historical section, the process of deinstitutionalization was intended to be a humane reformation of the institutionalized forms of treatment that had characterized mental health care prior to the 1960s. The discharge of patients from the institutions would be combined with a corresponding increase in the community support mechanisms. Today, it would appear that half of this equation is largely missing. To quote Dr. Voineskos (1983):

> "... the emptying of mental hospitals has thus become synonymous with deinstitutionalization. This is, however, a simplistic view because it does not include a second very important element of deinstitutionalization, defined by Bertram Brown and Leona Bachrach as the expansion and provision of community based

> treatment and support services for the mentally ill ..."

Throughout Canada, the number of psychiatric hospitals was decreased by one third in the eight year stretch between 1970 and 1978 (Toews and Barnes, 1982). The length of stay for both affective and psychotic illnesses also decreased by one third. In 1960, 50% of the 75,000 Canadians in mental institutions had been hospitalized for more than 7 years; today nine out of ten patients are hospitalized for less than 1 month. (Statement by The Honourable Larry Grossman, 1983.)

A shift in the location of treatment, from the large psychiatric hospitals to the smaller psychiatric units of general hospitals, has accompanied the reductions in psychiatric beds. In 1960, for example, 20,058 patients were housed within psychiatric hospitals while only 347 patients were admitted to the general psychiatric units. By 1976, 4,654 patients were in psychiatric hospitals with 1,425 patients in the general hospital units. (Statement by The Honourable Larry Grossman, 1983.) More recent figures show that in 1981, Toronto's 6 teaching hospitals had a combined total of 2,245 psychiatric admissions. (Medical Officer of Health, 1982.)

Despite the cutbacks in hospital beds, in 1979-80 Ontario spent $33 per capita on the hospital sector for 1% of the psychiatric population and $3 per capita on the community resources for 6.5% of the psychiatric population (Heseltine, 1982). Following the closing of the Lakeshore Psychiatric Hospital, only 10% of the available funds was channelled into local community services (Toews and Barnes, 1982). These figures appear to indicate that the push to move patients out of the psychiatric hospitals has not been matched with an equal zest to develop community support systems. The Queen Street Mental Health Centre (hereafter referred to as QSMHC) admission figures illustrate the need for more community support mechanisms, in that 67% of the total 3,636 admissions to QSMHC in 1981-82, were readmissions. Of the 3,636 patients admitted, 51.16% were at the stage of their lives that is considered to be the most productive - ages 20 to 40. (QSMHC, 1981/82.)

In fact, what has emerged out of this period of deinstitutionalization is a completely new generation of young adult patients. (Bachrach, 1982; Caton, 1981; Lamb, 1982; Pepper et al., 1981; Sheets et al., 1982; Schwartz and Goldfinger, 1981.) At one time it was believed that chronicity was largely due to the custodial nature of lengthy hospitalizations (Caton, 1981). However, the minimization of hospital stays has not eliminated chronicity. Instead, the new chronic patient is prone to repeated admissions and relies heavily upon existing community services. What develops is the "revolving-door" syndrome which, in combination with insufficient community supports for these patients, frequently provokes "severe system stress" (Bachrach, 1982). Consequently, the psychiatric emergency service "has become the semipermeable membrane of the community mental health system" (Schwartz et al., 1972). If hospitalized, the problems which confronted the patient in the community begin again immediately upon discharge.

Discharge Planning

A 1981 study of Metropolitan Toronto's system of psychiatric aftercare stated that approximately 7,000 psychiatric patients are discharged every 6 months (Community Resources Consultants/Clarke Institute, 1981). In the same study, 96% of those discharged were perceived by hospital staff as needing medical/therapeutic aftercare; 82% received referrals. Social/recreational needs were of such low priority that of the 43% of discharged patients perceived as needing referrals, only 12% actually obtained them. Some form of supportive housing was required by 23% of the patients; 10% were presented with referrals. The reasons for not referring a patient despite an obvious need were cited as: "patient not willing to accept referral" or "not a priority" or "patient to make own arrangements".

The above statistics seem to indicate that hospital staff largely ignore the non-medical forms of aftercare. The study concluded that this underutilization of aftercare services continues to create "an important barrier to aftercare service delivery". (Community Resources Consultants/Clarke Institute, 1981.)

Medication

The advent of the psychotropic drugs was one of the main forces that made deinstitutionalization possible. Patients could be discharged into the community after their condition was "stabilized" by means of medication. The study "Psychiatric Aftercare in Metropolitan Toronto" (referred to above), showed that the most common form of aftercare was chemotherapy. The emphasis of this medical approach was on treating the ex-patients as sick, not as disabled. (Community Resources Consultants/Clarke Institute, 1981, p.64) The authors went on to observe:

> "The very extensive use of chemotherapy in our subjects raises some concerns. It is well established that anti-psychotic medication is effective in the treatment of schizophrenia for both acute and chronic states. However, like most medications, anti-psychotic drugs possess inherent long and short-term risks that must be weighed against their benefits. In particular, there is mounting concern about the prevalence of tardive dyskinesia in patients maintained

> for long periods on anti-psychotic drugs."
> (Community Resources Consultants/Clarke
> Institute, 1981, p.65)

These concerns are shared by a variety of consumer groups. In a survey of consumers of mental health services, the Coalition On Psychiatric Services (COPS) concluded that in-patients and out-patients may lack adequate information about medication prescribed for them, and about possible side effects. (Coalition On Psychiatric Services, 1981).

In view of the fact that medication is the most common form of aftercare, the Clarke Institute aftercare study had this to say: "There is room for improvement in the delivery of psychiatric aftercare in Metropolitan Toronto. It is clear that psychosocial interventions are required to help patients maintain community adjustment. Drugs do not teach social and interpersonal skills." (Community Resources Consultants/Clarke Institute, 1981, p.68).

Housing Shortages

The Metropolitan Toronto Report of the "Task Force on Housing for Low-Income Single People" (1983), documents an increasing demand for affordable housing. Unemployment, low incomes and a lack of affordable rental accommodation has created a situation where homelessness or inadequate accommodation among single people is a real and growing problem. Many discharged psychiatric patients make up part of this homeless population.

A comprehensive survey of the housing options that exist for ex-psychiatric patients was conducted jointly by the City of Toronto Department of Public Health and the Supportive Housing Coalition (1982). In their study they noted that supportive housing is required for the majority of discharged psychiatric patients (53 - 62%) but due to deficiencies in appropriate housing the discharge of 26 - 31% of the patients may actually be delayed. Dr. Robert Buckingham, who chairs the Emergency Psychiatry Subcommittee of the Department of Psychiatry, University of Toronto, wrote to me as follows: "We wholeheartedly endorse any recommendation that would lead to an increased supply and variety of affordable, appropriate accommodation for this group. The inadequacy of the present supply of housing is apparent to those of us planning discharges back into the community." (January 20th, 1984)

Services for locating living accommodations report continual difficulties in establishing placements. Part of the problem originates from the Municipality of Metropolitan Toronto's general policy which requires individuals to have a permanent address before they can receive General Welfare Assistance (G.W.A.). Consequently, the ex-psychiatric patient is caught in a "Catch 22" situation - "no money, no place to live; no place, no money from welfare" (p.10). In an attempt to correct this situation, the Department of Community Services, upon receiving a call at the local General Welfare Assistance Office from a hospital staff member, will issue approximately $50 to the ex-psychiatric patient to find accommodation. However, the willingness of the general welfare assistance officers to grant the money and the hospital discharge planners' awareness of this system appears to vary from case to case. (City of Toronto D.P.H./Supportive Housing Coalition, 1982.)

According to this same study, discharged psychiatric patients who move into boarding houses must subsequently pay almost 89% of their maximum general welfare assistance monthly allowance on room and board. Statistics Canada, in estimating the poverty line, assumes that anyone who spends more than 58.5% of his or her gross income on the basic necessities of food, clothing and shelter, is poor. (Social Planning Council of Metropolitan Toronto (SPC) and the Ontario Development Council, 1983.)

Former psychiatric patients who can qualify as "disabled" by provincial standards are entitled to the Family Benefits Allowance. (F.B.A.). In 1983, a single F.B.A. recipient annually received $1,624. more than the single G.W.A. recipient. (SPC/Ontario Development Council, 1983.) However, unlike most other forms of rental housing, the rent charged in the majority of boarding homes is often geared to income so that the F.B.A. recipient usually pays more for room and board than the G.W.A. recipient. As well, any financial increases in the General Welfare or Family Benefits allowance levels are usually absorbed immediately by the landlord's raising the cost of room and board proportionate to the amount of increase, leaving the resident no further ahead. Provincial and Metro officials have reasoned that as long as this is the situation, a substantial increase in assistance will not really benefit the recipient.

A considerable number of ex-psychiatric patients are currently homeless. Eighteen hostels in Metro Toronto, with a total bed capacity of 1,740. provide short term or emergency accommodation. In order to estimate the number of ex-psychiatric patients seeking accommodation in these hostels, the "Housing Gap" study (City of Toronto D.P.H./Supportive Housing Coalition, 1982) conducted a one night survey of all the hostels. The survey asked two key questions; "How many people known to have some history of psychiatric contact stayed in the hostel tonight? (i.e. on medication, referred from mental health service, own statement)" and "How many people who probably have some history of psychiatric contact stayed in the hostel tonight? (i.e. bizarre behaviour, confused, delusioned, hallucinating, other)" (p.15). A total of 249 people or 17% of the residents had either a "known or probable" psychiatric history.

Conducting their own study, Nellie's Hostel reported that as many as 40% of their residents had recent psychiatric histories and 57% of the women lacked any source of income. (Guyton, 1982.) Ninety-five percent of the women in the study were in need of a greater level of supportive care than available at Nellie's, but there was no alternative. While one cannot conclude that a person with a "past or probable psychiatric history" is necessarily someone who is "chronically mentally ill", the fact that these individuals were residing in emergency housing and that the percentage in need of supportive care was so high, is indicative, I feel, of an unmet need.

Even hostels cannot always guarantee accommodation for ex-psychiatric patients. According to the "Housing Gap" study (City of Toronto D.P.H./Supportive Housing Coalition, 1982), most of the hostels have developed "barred lists" or "caution alert" lists. This study's examination of the lists of 6 hostels revealed that 68% of the persons on their "barred lists" and 67% of the people on the "caution alert" lists had psychiatric histories. Hostel staff stated that their own inadequate training and insufficient numbers made it very difficult to handle a resident in crisis. Furthermore, hospitals' reluctance to admit those who have previously disrupted the hostel because of psychiatric problems has proven to be a regular source of frustration for hostel staff who try to find alternative placements for residents in crisis.

The Supportive Housing Coalition contends that a definite correlation exists between squalid housing and the exacerbation of a patient's condition, but it is difficult to support this contention with exact figures. Diane Capponi, a discharged psychiatric patient who spoke at the Task Force public meeting held in Parkdale in September, 1983, has been quoted in Phoenix Rising: "More than likely you are going to end up back at Queen Street, not because of the problems that originally put you into Queen Street, but because of the problems that you have to face in a boarding house. It's just a terrifying horror story". (Grant, 1982.)

Housing Options

The Supportive Housing Coalition has clearly identified the need for a wide spectrum of supportive housing models that would offer anything from 24-hour supervision to weekly support and on-call supervision. (Supportive Housing Coalition, 1982.) To reach these objectives, in 1981 they recommended that an additional 270 housing alternative beds be funded and that a mandated agency organize enrichment services to boarding homes and hostels. In response to representations from the Supportive Housing Coalition and others, the Ministry of Health has approved funding for approximately 190 beds under its Community Mental Health Program. At the present time, the Supportive Housing Coalition, in conjunction with other community agencies and groups, is in the process of developing alternative community housing operations that combine the available funded beds with a range of appropriate support services.

1) Alternative Community Housing (Non-Profit)

A. Cooperative Housing

Houselink Community Homes, an example of a non-profit housing project, operates more than a dozen co-ed and cooperative apartments and houses throughout Metro Toronto. (Campbell, 1983.) Each home accommodates four or five people and as there are no live-in staff, the residents must establish their own house rules, pay their own rent, etc. Houselink's goal is to keep the housing affordable at $89 to $145 per person per month, (this does not include board). Even so, housing price increases and "exclusionary" zoning by-laws outside the City of Toronto have made this increasingly difficult. The project's houses are not classified as "group homes" according to most municipal by-laws or the provincial definition. The Ministry of Health under the Community Mental Health Service Program funds Houselink. Recently, Houselink has been granted a loan from Canada Mortgage and Housing Corporation to purchase a new house. The Ministry of Housing has committed itself to subsidizing the rent in this particular home: an important and commendable development.

Studies have shown that residents who benefit from these forms of "high expectations" halfway houses achieve a greater level of vocational and social functioning when compared to non-resident control groups. (Houselink Community Homes, 1981; Lamb and Goertzel, 1971). The opportunity to participate in these enrichment programs, however, appears to be available to only a select group. The Lamb and Goertzel study concluded that it is the acute, articulate patient, not the long term chronic patient, who is usually referred to these homes. Houselink's (1982) own research confirms these findings. The average Houselink resident is 30 years old and non-transient with a secondary or post-secondary education. Only 18% of the residents had lived in a boarding house during the year prior to moving into the cooperative house.

B. Group Homes

Although this is the term most often used to describe a particular form of high support housing, the technical term used by the City of Toronto in its zoning by-law is "residential care facility".

The Province has developed this definition of a group home:

> "... a single housekeeping unit in a residential dwelling in which three to ten unrelated residents live as a family under responsible supervision consistent with the requirements of its residents. The home is licensed or approved under Provincial Statute in compliance with municipal by-laws." (Polak, 1983.)

At the present time, it is the policy of the Government of Ontario not to "legislate" group homes. The policy is one of "... encouraging (but not requiring) municipalities to amend their official plans and zoning by-laws to permit group homes in all residential areas without the need for site-specific amendments." (Ontario Group Homes Resource Manual, Secretariat for Social Development.) To quote the former Provincial Secretary for Social Development, Margaret Birch: "The philosophy and the intent of this government is to achieve our objectives through cooperation with municipalities." (Statement by The Honourable Margaret Birch to the Ontario Legislative Assembly, 1978.)

The Metropolitan Toronto Council adopted an official plan for group homes on June 8, 1979 (approved by the Minister of Municipal Affairs and Housing on April 16, 1981) which recommended that the municipalities should permit group homes through as-of-right zoning. (Municipality of Metropolitan Toronto, 1983.) The Metropolitan Council reaffirmed this policy of requiring a Metro-wide distribution of group homes on April 14, 1982. On May 10, 1983 this policy was modified to exclude only correctional group homes. Objections by certain municipalities and ratepayers to the Metro policy have been lodged with the Ontario Municipal Board. The hearing commenced on January 23 of this year and continues at the time of writing (February, 1984).

Until the Ontario Municipal Board makes its decision, the existing disparity among the various Cities and Borough that constitute Metropolitan Toronto in respect to group home by-laws will continue to be substantial. For example, North York has a group home by-law that specifies distancing factors, permits only single detached homes to be utilized and stipulates that the number of residents be from three to ten in number. The Supportive Housing Coalition (Polak, 1983) argues that this by-law prevents those who do not require large home accommodation with 24-hour supervision from living in 3 - 5 person units of close proximity with shared supervision.

The City of Toronto, which passed a group home by-law in 1978, "has one of the most progressive and supportive group home policies of any North American city ... the City of Toronto stands alone with its policy of permitting all types of group homes in all residential districts with minimal restrictions". (Municipality of Metropolitan Toronto, 1983.)

2) Boarding Homes

At the present time, there are 698 licensed and 330 unlicensed rooming and boarding houses within Metropolitan Toronto. (Toronto Department of Buildings and Inspections, 1983.) The Municipal Act (R.S.O., 1980, Chapter 379, Section 46) allows for but does not require municipal licensing, regulation and inspection of "boarding homes", per se. One report recommended that the authority for licensing and regulation should be delegated under this Act to the local Boards of Health, but additional municipal by-laws would be required. (Metropolitan Toronto Social Services and Housing Committee, 1980.)

Municipalities in Ontario regulate boarding homes to differing degrees, and this has led to uneven development and concentration of residential facilities. (Municipality of Metropolitan Toronto, 1983.) Only two municipalities in Metro permit licensed boarding homes - the Cities of Etobicoke and Toronto - and their by-laws control the physical standards but not the quality of service or care.

As of April 1, 1981 a new licensing by-law in the City of Hamilton recognized "second-level" lodging houses. These facilities: have four or more residents; provide operators who, for a fee, offer counselling on "activities of daily living" and provide 24-hour supervision; comply with building, fire and safety regulations. There has been a policy decision (by the Regional Municipality of Hamilton-Wentworth) to establish contracts with operators of certain of the "second-level lodging houses" providing financial assistance (domiciliary hostel funds) to those operators who maintain a defined standard of care as per the by-law and the contract which each owner/operator of such a house has made with the Regional Municipality. Approximately half of the residents in these contract homes are discharged psychiatric patients.

In the City of Hamilton, 27 "second-level lodging homes" are referred to as contract lodging homes, i.e. operators must provide 24-hour supervision, monitor residents' medication intake etc., but programming is not required of these licensed boarding homes. (Social Planning and Research Council of Hamilton and District, 1981.)

3) Approved Homes and Homes for Special Care

The Approved Homes Program functions under the Mental Hospital Act and is administered by the local provincial psychiatric hospital. The program is intended to provide short-term, transitional support to in-patients who are soon to be discharged from the hospital. The number of Approved Home beds is steadily decreasing. The Community Resources Consultants' study (1982) reported that 135 Approved Home beds existed in Metropolitan Toronto in 1974 while in 1982 there were only 43 beds in Metro Toronto. Today, there exists a total of 25 Approved Home beds within the City of Toronto; 13 of these are QSMHC beds and 12 are Whitby Hospital beds. Another 11 Whitby beds are in the planning stages. (Marie Chapeskie, Community Resources Consultants of Toronto, Pers. Comm., August 4, 1983).

Homes for Special Care come under the legislative authority of the Homes for Special Care Act (1964). (Metropolitan Toronto D.H.C., 1983.) These homes, classified as either "residential" or "nursing", are licensed annually by the Province and are in compliance with municipal by-laws but inspected by the Province. Their mandate is to provide long-term stable housing with 24-hour supervision and care as required. The homes come under the jurisdiction of the sponsoring provincial psychiatric hospital. In the case of Metro Toronto, which is served by two provincial psychiatric hospitals, the majority of H.S.C. beds are outside Metro's boundaries. The most recent figures show that within the City of Toronto there are 50 "residential" beds (26 from QSMHC and 24 from Whitby) and 75 "nursing" beds. (Marie Chapeskie, C.R.C.T., Pers. Comm., August 4, 1983). Both homes for special care and approved homes are considered to be "group homes" under the City of Toronto Zoning by-law and the Provincial group home definition.

Psychiatric Aftercare Service

A health care needs assessment was conducted in the Parkdale area of Toronto over the summer of 1983 (M. Harding Consulting and Oasis Policy Research Group, 1983). Ex-psychiatric patients were identified as one of the four major, high-risk target groups. Some of the most pressing socio-health problems experienced by this group were the lack of medical services, housing, income security and the lack of rehabilitational, vocational, educational and recreational services. With respect to barriers to services, it was found that the effort required to cope with the basic problems of survival generated high stress and left little energy to deal with primary health problems. Something as simple as using a phone to make appointments or paying for transportation, was hampered by inadequate financial resources. Furthermore, ex-psychiatric patients' tendency to distrust social/health services provided reason not to seek assistance.

This study found that the Emergency Department at St. Joseph's hospital was likely to be used inappropriately, which meant that the waiting time was long and if the patient was known to have a psychiatric history then the presenting physical ailment was often not treated seriously, suggestive of the "severe system stress" which Bachrach (1982) described. It was recommended by two of the respondents working in the mental health field that a mobile crisis intervention unit be established.

The Metropolitan District Health Council has reported that a comprehensive mental health service would comprise the following: (Metropolitan Toronto D.H.C., 1983.)

Hospitalization
Discharge Planning
Partial Hospitalization
Day Treatment
Outpatient Treatment
Crisis Intervention
Continuity of Care
Cooperation
Coordination
Data Development
Supportive Housing
Financial Assistance
Vocational Training
Social/Recreational Programs
Case Management

The aftercare components of this model have been researched extensively and changes have been ongoing for at least the past year. During the course of this Task Force, many of these program changes have moved from the theoretical to the practical. I will comment further on these changes in the Aftercare chapter of this report.

The Community Resources Consultants of Toronto is designed to be a "service for services". C.R.C.T. also provides community rehabilitation services. This program employs 3 1/2 Rehabilitation Specialists and four Rehabilitation Assistants whose job is to devise a community support network for their clients. (Community Resource Consultants of Toronto, 1981.)

The idea of Rehabilitation Specialists is not unique to the C.R.C.T. In September 1982, the Clarke Institute of Psychiatry Consulting Group recommended that 10 case managers be added to the existing staff of the satellite clinic, Archway, in order to follow clients on a long-term basis. (The Clarke Institute of Psychiatry Consulting Group, 1982.) The first Heseltine report, "Blueprint for Change: The Next Ten Years" also recommended the use of case managers. (Heseltine, 1982.)

As an outcome of these two reports, the Ministry of Health was to have arranged funding for a team coordinator plus 10 case managers and support staff to supplement the Archway staff. (Statement by The Honourable Larry Grossman, 1983.) To date, the Team Coordinator has been employed and the hiring of the 10 case managers is almost complete.

Concern over the lack of coordination of mental health services has resulted in several studies still in progress. The Metropolitan Toronto District Health Council is conducting a study on coordination and crisis intervention, which is expected to be completed by mid-1984. (Metropolitan Toronto D.H.C., 1983.) Meanwhile, on June 7, 1983, the Clarke Institute of Psychiatry Consulting Group presented their first draft of a report entitled "Consultation Report: Systems Coordination for Psychiatric Services in Toronto" to the Parkdale Working Group, convened by the Ministry of Health. Ironically, as the Consulting Group notes, the independent initiation of two studies on the same topic (three, if we include this Task Force) demonstrates perfectly the lack of coordination at all levels. Subsequent links have been made between these separate groups. Nevertheless, "the fact remains that if a system for coordination already had been in place, perhaps a more collaborative, global approach to planning might have been possible from the outset". (Clarke Institute of Psychiatry Consulting Group, 1983, p.18.)

Although many studies call for better coordination and linkage of services, the "Consultation Report on Systems Coordination for Psychiatric Services in Toronto" is unique in that it actually describes a detailed working model for coordination and outlines the steps required to implement this model. It is believed that the addition of 10 new case managers to Archway's program must go hand in hand with a system of interagency coordination. This consultation report recommended that the Mental Health Division of the Ministry of Health consider the development of a pilot project that will integrate services for ex-psychiatric patients residing in Parkdale (and other parts of what the City's Department of Public Health calls the Western Health Area). It is possible for such a pilot project to be expanded to serve the City of Toronto's Department of Public Health and to ultimately become a Metro-wide mechanism of coordinated services for all ex-psychiatric patients. The consultation report recommended that the funding for the pilot project be provided by the Ministry of Health and administered through the Toronto Department of Public Health. There would be regular and direct reporting from the project staff to the Medical Officer of Health and to a designate of the Ministry. At present, implementation of this particular model has not occurred, but the changes which have been made will be described in the Aftercare chapter of this report.

The study by the Supportive Housing Coalition and the Department of Public Health, entitled "The Housing Gap", (1982) recommends that the Ministry of Health should: provide funding for a comprehensive range of supportive housing; establish a 24-hour crisis team with a 15-bed crisis facility for those who are experiencing difficulties coping with their present residence; initiate a system to collect and monitor information on patients' housing situations, both pre-admission and post-discharge. The report further suggests that the Metro Toronto Community Services Department should increase the present allowance rates and remove the "Catch 22" situation that prevents someone without housing from receiving G.W.A. and someone without income (G.W.A.) from being able to obtain housing.

Underlying all of these issues in aftercare planning is the problem of income for ex-psychiatric patients. But, as noted by the psychiatric aftercare study (Community Resources Consultants/Clarke Institute of Psychiatry, 1981) "financial management is relatively neglected as an important component of aftercare". To focus solely on the housing for ex-psychiatric patients is to ignore the monetary reasons for their living in such impoverished surroundings. "The Housing Gap" report does recommend that the Metro Toronto Community Services Department increase the allowance rates. The Metro Toronto Community Services and Housing Committee (1980) in turn recommends that the Ministry of Community and Social Services and the Ministry of Health ensure that psychiatrically disabled people receive income under the Family Benefits Act as opposed to General Welfare Assistance. Recently, the Minister of Community and Social Services, Frank Drea, announced that certain recipients of FBA would receive an increase.

Income is also tied to employment. The Community Occupational Therapy Associates (C.O.T.A.) has found that a high percentage of ex-psychiatric patients are unemployed. Employers are not generally sympathetic to the plight of the psychiatric patient. Government incentive programs for the disabled tend to give priority to the physically disabled. There is a need for more creative employment programs that would allow for partial and/or shared employment for discharged psychiatric patients - another group with a disability. (Anderson, 1983.) This need is explored further in the Work chapter of this Final Report.

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6. HOUSING

The review of the literature contained in the previous chapter of this report illustrates that the need for appropriate, affordable accommodation has been extensively documented in a number of reports, such as The Housing Gap, Community Housing for Consumers of Mental Health Services in Metropolitan Toronto, Adult Residential Facilities, Boarding Homes and Lodging Houses. In response to my Preliminary Report, Dr. Robert Buckingham, who chairs the Emergency Psychiatry Subcommittee of the Department of Psychiatry, University of Toronto, wrote:

> "We wholeheartedly endorse any recommendation that would lead to an increased supply and variety of affordable, appropriate accommodation for this group. The inadequacy of the present supply of housing is apparent to those of us planning discharges back into the community". (Letter to the Task Force dated January 20th, 1984.)

A strong consensus has developed that the most crucial first step to be taken in resolving many of the "aftercare" issues is to improve the housing options available to the population of discharged psychiatric patients whose limited income effectively dictates their choice of low cost housing.

At the municipal level, problems associated with housing of discharged psychiatric patients have generated concern in the neighbourhoods that have housing stock best adapted for use as "boarding homes" and "group homes". On several occasions over the years and continuing to date, this has been manifested as a political issue when residents of these neighbourhoods have directed their concerns toward their elected municipal and provincial representatives.

In what has come to be known as the Supportive Housing Coalition (SHC) "blueprint" (Community Housing for Consumers of Mental Health Services in Metropolitan Toronto, September, 1981), several important assumptions with which I concur are stated:

- First, that mental health services, including housing, are best provided in the community;

- Second, that communities must develop the capacity to provide these services in a coordinated fashion;

- Third, changes will only occur if all levels of government are prepared to participate in finding solutions.

The term "supportive housing" is itself instructive: we cannot expect that by simply improving physical standards we will also be solving the problem. The support services structure available to chronic mentally ill people must be revised and more effectively linked to their housing. To accomplish this end, a full range of supportive housing needs to be developed in communities throughout the City of Toronto and indeed, Metro Toronto. This, of course, is the objective of the amendments to Metroplan which are currently before the Ontario Municipal Board (February, 1984).

The Supportive Housing Coalition identified four levels of care associated with such housing, ranging from one to four people living independently with access to on-call supervision (Level IV: provided by groups such as Houselink), to long-term high support facilities with extensive supervision (Level I: provided in group homes set up through the SHC). Although useful for detailed planning, the Levels I to IV designation is not yet widely understood or utilized and in many areas, this range of housing does not yet exist. Thus, this section of the Report is not organized using that terminology. Rather, the discussion emphasizes changes to be made to the types of housing described most often as "group homes" and "boarding homes" and "hostels." Background information derived from the current literature has already been referenced in the previous chapter of this report.

Residential Care Facilities (Group Homes)

During the summer of 1982, the City of Toronto's Parkdale area was the scene of considerable public outcry against group home proposals and boarding homes perceived as "group homes". Similar concerns were heard in other wards in the City and extensive Council debate ensued. At that time, Council re-affirmed its as-of-right zoning policy for group homes. Unfortunately, other municipalities in Metropolitan Toronto have not yet enacted such a policy, even though the Provincial Government has continued to hold to its policy of encouragement for such zoning. A confusion as to what constitutes a "group home" continues to operate. In particular, many people seem to think that a group home is the same thing as a boarding home. Failure to distinguish between these two very different types of housing has only delayed the development of solutions.

In the City of Toronto, a group home is termed a "residential-care facility" and is defined in the zoning by-law as:

"(112C) "residential care facility" means a residence for the accommodation of six to ten persons, exclusive of staff, who by reason of their emotional, mental, social or physical condition or legal status require a group living arrangement for their well-being; and:

> "(a) such facility is supervised, or the members of the group are referred, by a hospital, court or government agency; or
>
> "(b) such facility is funded wholly or in part by any government, other than funding provided solely for capital purposes; or
>
> "(c) such facility is regulated or supervised under any general or special Act;
>
> "but does not include any use otherwise classified or defined in this by-law; (332-78)"

The authors of a Canadian study recently published as a book entitled not on our street (M.J. Dear & S.M. Taylor, Pion Limited, 1982) examined the placement of ex-psychiatric patients in group homes and demonstrated that those with tolerant attitudes are more the norm than the vocal critics who have often dominated community discussion when plans to locate a group home in their neighbourhood have been announced.

At the September, 1983 public meeting that the Task Force held in Parkdale, consumers of mental health services spoke strongly in favour of group homes as an option in supportive housing. I have found that the consensus among consumers, service providers and government officials is to endorse the increased availability of this type of housing.

However, it must also be noted that "group homes" are an example of high support housing, which requires extensive preliminary planning and community support as well as a considerable financial commitment (usually from the Provincial Government) before being put in place. Furthermore, the City of Toronto is, at the time of this report, February, 1984, the only municipality in Metro Toronto which has zoning by-laws that allow for "as-of-right" location of all types of group homes that meet the definition of "residential care facility". The City of North York restricts the location of correctional group homes but allows "as-of-right" location of group homes for discharged psychiatric patients. Only the City of Etobicoke continues to prohibit all types of group homes. It is therefore encouraging to observe the firm stand taken by the Province and Metro Toronto on this issue. (Application by the Honourable Claude F. Bennett, Minister of Municipal Affairs and Housing, on a request by The Municipality of Metropolitan Toronto: Hearing before the Ontario Municipal Board which commenced January 23, 1984.) Clearly, a favourable decision by the Ontario Municipal Board on this issue will be pivotal to the much needed expansion of group homes in all of the municipalities in Metro Toronto.

Recommendations

Because this report is to be released at a time when zoning by-laws in Metro Toronto may soon change, it did not seem sensible to formulate a proposal whereby group homes for discharged psychiatric patients would be substantially increased in number, until the outcome of the current Ontario Municipal Board hearing is known, even though I consider that to be a desirable and essential goal.

Instead, I have sought to recommend a course of action that will further demonstrate the commitment of the City of Toronto and of Metropolitan Toronto to the concept of group homes for discharged psychiatric patients.

RECOMMENDATION #1: THAT THE COUNCIL OF THE CITY OF TORONTO RE-AFFIRM ITS SUPPORT IN PRINCIPLE FOR GROUP HOMES AS A NECESSARY COMPONENT IN THE RANGE OF SUPPORTIVE HOUSING FOR DISCHARGED PSYCHIATRIC PATIENTS.

RECOMMENDATION #2: THAT THE COUNCILS OF METROPOLITAN TORONTO AND THE CITY OF TORONTO DEMONSTRATE THEIR COMMITMENT TO THE SOCIAL BENEFITS OF GROUP HOMES BY MAKING AVAILABLE AT A NOMINAL COST ONE HOUSE EACH WHICH IS SUITABLE FOR IMMEDIATE USE AS A NON-PROFIT GROUP HOME FOR DISCHARGED PSYCHIATRIC PATIENTS. THAT THE APPROPRIATE METRO AND CITY STAFF REPORT, IN CONSULTATION WITH THE SUPPORTIVE HOUSING COALITION, ON THE LOCATION, REPAIR AND

OPERATION OF EACH SUCH HOME IN ORDER THAT THEY BE IN OPERATION BY THE FALL OF 1984.

Boarding Homes

Unlike residential care facilities (group homes), boarding homes do not provide a structured group living arrangement as a necessary part of their operation. For many residents, their economic limitations necessitate their choice of a boarding home as a place to live, once discharged from a psychiatric facility. As with the term "group home," boarding home is not used in the existing City of Toronto by-laws. However, the term "boarding home" is generally understood to mean a rooming house where meals are provided as part of the rental charge. Similarly, "lodging house" is a term used to describe such rooming houses. In fact, the City of Toronto issues licences to operators of lodging houses who make applications and meet the standards administered by the Department of Buildings and Inspections. The Commissioner of the City of Toronto Housing Department, George C. Cook, recently co-authored a report to the Parkdale Working Group that suggested that Housing By-law 73-68 could be amended to include a definition of boarding home to the effect that a "boarding house is a rooming house where the owner or operator undertakes to provide meals to the occupants of the boarding house either on the premises or in another building operated by the owner and that the provision of the meals forms a part of the rental income of the owner or the operator." It was further suggested that such boarding houses be included as a class of rooming house in the Rooming House Licensing By-law.

In March and November of 1983, the Ministry of Community and Social Services announced a new program to be known as "Ecuhome", developed in conjunction with a number of churches. $1.5 million has been allocated to this project and the Anglican Church of Canada has agreed to initiate the project and invest its own funds. Although not yet operative, the boarding homes are anticipated to service "disadvantaged" residents, many of whom will not be psychiatrically disabled, but who are recipients of General Welfare Assistance administered by Metropolitan Toronto or Family Benefits Allowance administered by the Province and living in the western (Parkdale) and eastern areas of the City.

While Ecuhome is certainly a model for one type of supportive housing, it should not be relied upon as the principal source of improving the boarding homes whose primary clientele are discharged psychiatric patients.

During the past 10 years the City of Toronto has on numerous occasions identified problems with the housing available to discharged psychiatric patients. It has been recognized for some time that a substantial number of the chronic mentally ill on low incomes have tended to concentrate in areas where boarding homes are numerous. Considerable research and discussion has centered on the idea of enacting by-laws that would govern improved physical and personal care standards in boarding homes. Repeatedly, City officials have been faced with the harsh reality that people living in many of these boarding homes literally have nowhere to go but the street if the homes are closed due to infractions of the Housing Standards by-law. As well, recent study has indicated that many of the operators of these boarding homes should not be made the scapegoats for the poor living conditions to which many discharged psychiatric patients are subjected (Report of Housing Sub-Committee of the Parkdale Working Group, June, 1983). Rather, it now seems that in many cases, boarding homes are business operations with marginal, if any, profit. Understandably there exists a reluctance to enact further amendments which would only add to the standards which are already difficult to enforce without causing undue hardship to residents.

The previously mentioned Report of the Housing Sub-Committee concluded that "additional standards should not be applied in any circumstance unless there is an adequate financial package attached which will permit owners of boarding houses to meet the additional requirements." The Report goes on to note that in order to meet the standards recommended, most owners will lose rented space for non rent-producing uses, for example, bedrooms will be converted to kitchens, bathrooms etc. Concern was expressed that "additional renovation costs and loss of operating revenue would ... lead to many of these properties going out of the boarding house business." Very specific proposals as to additional standards governing "boarding houses" to be included in the City of Toronto Housing By-law 73-68 are made in the Parkdale Working Group Housing Sub-Committee report.

With regard to standards of care to be applied to boarding houses, the Housing Sub-Committee of the Parkdale Working Group concluded that "it may not be necessary to impose such standards by regulation or by-law, provided that the financial package is so designed that the money is paid directly to the operator on the condition that the property remains in use for the housing of discharged psychiatric patients and that the conditions of operation are such that they satisfy the standards imposed by the appropriate regulating agency. Failure to meet these standards should result in the removal of the financial assistance."

In the course of deliberations on this question, the report mentioned above has been considered at some length. As well, consultations have been held with officials from the City of Toronto, Metropolitan Toronto, the Ministry of Health, the Ministry of Community and Social Services, the Ministry of Housing, and the Secretariat for Social Development.

The Contract Aftercare Project (C.A.P.)

The result of these consultations on the question of standard of care to be applied to boarding houses is contained in my proposal for the Contract Aftercare Project. While I certainly do not consider this proposal to be the panacea to the unmet housing needs of discharged psychiatric patients, I do feel that acknowledging and addressing the reality of where large numbers of chronic psychiatrically disabled people live and attempting to improve the standards within that housing is a necessary and practical "first step". This is a proposal for a means by which the Province would provide funding and the City of Toronto would provide most of the human resources needed to enable certain owner/operators of boarding homes which cater primarily to discharged psychiatric patients to upgrade the physical standards of their boarding homes and, in turn, the service standard as well. This proposal does not necessitate the enactment of new by-laws or additional amendments to existing City by-laws, but it may require enabling legislation to be enacted by the Province to allow City officials to enforce adequately the terms of the contracts which will govern the operation of the boarding homes under C.A.P.

As the Parkdale Working Group Report has already noted, the upgrading of these boarding homes may well result in a loss of income-producing space and the temporary dislocation of some residents. However, I would anticipate that the increased property value and the advantages of operating a facility which meets the City's housing standards will provide a real incentive to many owners/operators. As well, the potential dislocation of residents is to be addressed before any renovations commence, in that "turn-around space" must be created as an option for residents of C.A.P. houses who wish to avail themselves of such alternative housing.

In response to the Preliminary Report of the Task Force, Alderman Richard Gilbert expressed the concern that I seemed to be proposing that the City of Toronto undertake to provide "per diem" payments to boarding home operators in a manner similar to the Regional Municipality of Hamilton-Wentworth, which funds domiciliary care provided by operators of "second-level lodging houses" regulated under municipal by-law. I wish to emphasize that I am not making such a proposal. While I do not rule out the desirability for some sort of "per diem" funding for the delivery of services, I have not included this as part of the C.A.P. proposal. Rather, the proposal has been designed with the expectation that financial assistance for the physical upgrading of C.A.P. boarding homes will enable owner/operators to undertake the provision of improved services to residents. Furthermore, C.A.P. has been designed to allow individual residents in boarding houses to receive services from a variety of agencies to meet their personal needs, just as individuals living in other housing forms throughout the community receive services from agencies such as the Department of Public Health and Community Occupational Therapy Associates.

The Department of Buildings and Inspections informed the Special Committee on Boarding and Lodging Houses in Ward 2, chaired by Alderman Ben Grys, that there are 717 rooming houses in the City of Toronto (as of January, 1984). Some of these houses will not be suitable for funding assistance under C.A.P. and of the many potential houses, only some will be good choices for the beginning of the Project. While I do not think a limit should be placed on the total number of houses upgraded under C.A.P., it does seem reasonable to begin slowly and carefully so as to ensure that all possible provision has been made for the success of this program. I have based my recommendation on consultations with officials at all three levels (City, Metro, Province), who advised me that a methodical approach is in the long run more appropriate for the ultimate success of such a process.

In response to my preliminary recommendations, one of the concerns expressed about C.A.P. was that the upgrading of standards reflected in the prototype contract (now found in Appendix A) would lead to the boarding homes being designated as residential care facilities under the City of Toronto Zoning By-law. On advice from the City's Solicitor, I have explored this question further and am pleased to report that the Commissioner of Planning and Development has informed me that "... a C.A.P. house would be classified as a boarding and lodging house and not as a residential care facility." (Correspondence dated January 27, 1984) I also consulted with officials in the Department of Buildings and Inspections and received the following opinion from the Deputy Commissioner, R. Bonner:

> "I do not think the funding or the degree of supervision to be applied to the C.A.P. houses have the effect of transferring a licensed lodging house into a residential care facility for the following reasons:

"1. You indicate in your letter that funding provided by the Province would be applied to the physical rehabilitation of the lodging houses chosen to participate in C.A.P. and that there is no provision for funding on a per diem basis or to be directed to the owner/operator to cover the cost of employees.

"Since Article (b) of Section 2 (112C) of the Zoning By-law calls for funding by any government other than funding provided solely for capital purposes, I think therefore, this Article does not apply in this case. However, if funding in the future may be provided by the government for any purpose other than capital purposes, the use might fall within the definition of a residential care facility.

"2. You indicate in your letter that the residents of such houses are not necessarily always referred by a hospital, court or government agency nor the facilities supervised by them.

Therefore, Article (a) of S.2 (112C) of the Zoning By-law does not seem to apply.

"3. I do not have any information whether such facilities are regulated or supervised under any general or special Act. I do not believe the Rooming House By-law or its enabling legislation is the type of Act mentioned in Article (c) of S.2 (112C).

"In any case, if the group living arrangement is not required because of the residents' mental, emotional, social or physical well-being or legal status, but chosen for economic reasons as stated in your letter or if there are less than six or more than ten residents in the C.A.P. houses the definition of a "residential care facility" does not apply."

Recommendation

As an important initial step toward effectively improving the standards in boarding homes that cater primarily to discharged psychiatric patients without reducing unnecessarily the housing available to these residents, I have tried to devise a proposal, to be phased in as quickly as possible, that will not require the enactment of any additional by-laws involving housing standards.

RECOMMENDATION #3: THAT THE PROVINCE OF ONTARIO IN COOPERATION WITH THE CITY OF TORONTO DEVELOP AND PUT IN PLACE THE CONTRACT AFTERCARE PROJECT, (C.A.P.) TO COMPRISE THE FOLLOWING COMPONENTS:

1) AN AGREEMENT BETWEEN THE PROVINCE OF ONTARIO AND THE CITY OF TORONTO BY WHICH THE PROVINCE PROVIDES ALL NECESSARY FINANCIAL RESOURCES FOR THE REPAIR AND REHABILITATION OF AT LEAST 10 EXISTING BOARDING HOUSES IN THE CITY OF TORONTO, BEGINNING IN, BUT NOT LIMITED TO THE PARKDALE NEIGHBOURHOOD, IN EXCHANGE FOR THE CITY'S UNDERTAKING TO IMPLEMENT, ADMINISTER AND MONITOR THE C.A.P.

2) HAVING RECEIVED THE FUNDS FROM THE PROVINCE, THE CITY WILL IN TURN ALLOCATE THESE PROVINCIAL FUNDS BY MEANS OF AN AGREEMENT WITH THE OWNER/OPERATOR OF AN EXISTING BOARDING HOUSE FOR REHABILITATION AND REPAIR OF THE PROPERTY IN EXCHANGE FOR:

    i) COMPLIANCE WITH PHYSICAL STANDARDS SPECIFIED IN A CONTRACT (SEE SCHEDULE A OF A DRAFT PROTOTYPE CONTRACT IN APPENDIX A);

    ii) THE PROVISION BY THE OWNER/OPERATOR OF SERVICES WHICH MEET STANDARDS SPECIFIED IN THE CONTRACT (SEE SCHEDULE B OF A DRAFT PROTOTYPE CONTRACT IN APPENDIX A);

    iii) AN UNDERTAKING GIVEN BY THE OWNER/OPERATOR OF THE PROPERTY IN QUESTION TO ENSURE ACCESS TO THE PREMISES BY A SERVICE AGENCY WHICH IS RECOGNIZED AND APPROVED BY THE IMPLEMENTATION COMMITTEE AND IS IN RECEIPT OF FUNDING FOR THE PROVISION OF AFTERCARE PROGRAMS TO RESIDENTS WHO CHOOSE TO RECEIVE SUCH SERVICES ON THE PREMISES IN QUESTION.

RECOMMENDATION #4: THAT THE C.A.P. BE ADMINISTERED BY AN IMPLEMENTATION COMMITTEE, WHOSE MEMBERSHIP WILL INCLUDE: THE CURRENT MEMBERS OF THE ALTERNATIVE HOUSING SUB-COMMITTEE OF THE NEIGHBOURHOODS COMMITTEE OF TORONTO CITY COUNCIL; ONE STAFF REPRESENTATIVE EACH FROM THE ONTARIO AND METROPOLITAN TORONTO GOVERNMENTS; A REPRESENTATIVE OF THE MEDICAL OFFICER OF HEALTH, AND THE COMMISSIONER OF BUILDINGS AND INSPECTIONS.

RECOMMENDATION #5: THAT THE RESPONSIBILITIES OF THE IMPLEMENTATION COMMITTEE COMMENCE IMMEDIATELY AND INCLUDE:

a) DEVELOPMENT OF A HIGH QUALITY INTERIM RESIDENTIAL FACILITY TO BE PUT IN PLACE PRIOR TO THE REPAIR OF ANY CONTRACT HOUSE TO BE AVAILABLE TO TENANTS WHO MAY BE DISPLACED DURING REPAIRS;

b) SELECTION BY PROPOSAL CALL AND IN CONSULTATION WITH THE APPROPRIATE WARD ALDERMEN OF THE CONTRACT HOUSES FOR THE PROJECT;

c) THE ADMINISTRATION OF THE CONTRACTS AND AGREEMENTS REFERRED TO IN RECOMMENDATION 3 AND THE IDENTIFICATION AND DIRECTION OF CITY STAFF TO CARRY OUT THE INSPECTION AND MONITORING OF THE CONTRACT HOUSES;

d) CONDUCTING OF ANNUAL REVIEWS AND RECOMMENDING APPROPRIATE CONTRACT RENEWALS TO CITY COUNCIL;

e) ENSURING THAT PRIORITY OF TENANCY IN THE UPGRADED CONTRACT HOUSES BE GIVEN TO THOSE WHO RESIDED IN THE HOUSE AT THE TIME THE CONTRACT WITH THE CITY WAS SIGNED.

RECOMMENDATION #6: THAT THE CITY SOLICITOR BE REQUESTED TO PREPARE DRAFT LEGISLATION AS NECESSARY TO ENABLE THE CITY'S PARTICIPATION IN THE C.A.P. BASED ON THE PROPOSALS SET OUT IN THIS REPORT FOR SUBMISSION TO THE CURRENT (SPRING SESSION) OF THE ONTARIO LEGISLATURE.

Appendix A contains a possible prototype contract to be used as the basis for developing an agreement which will specify the essential elements of C.A.P. It has been included to give readers a concrete idea of the physical and service standards to be met by owner/operators under C.A.P.

The requirements are consistent with existing standards in City by-laws. The service standards in Schedule 'B' are not the subject of existing City by-laws.

Legal Status of Discharged Psychiatric Patients Who Reside in Boarding Homes

In response to Council's request that I report on this question, I have turned to Parkdale Community Legal Services Inc. (PCLS) for an opinion. Having served low-income clients in Parkdale for more than 10 years, PCLS seemed a valuable source of expertise on this question and I am indebted to the Director, Mary Hogan, and her staff for their contributions to the Task Force Reports and to the November, 1983 Public Hearing of the Task Force. The full text of the PCLS opinion can be found in Appendix C.

Introduction to the Problem

The City of Toronto had 698 licensed rooming and boarding houses and 330 unlicensed rooming and boarding houses including properties where an application for a license was being processed (Report of City of Toronto Department of Buildings & Inspections, January 11, 1983). In Ward 2, the Parkdale area, there are 95 licensed rooming houses and 49 that are known to be unlicensed. The breakdown by City wards shows that Ward 2 ranks fourth in the number of rooming houses in both categories for which statistics are available. PCLS reports that its caseload reflects a great number of problems in this area of housing. It is likely that the "South Parkdale By-law", By-law 67-78, has, since its enactment in January of 1978, had the effect of limiting the number of new licensed boarding houses in the ward as it prohibits a property's conversion to a boarding or lodging house as a legal land use in the area bounded by Queen Street, Dufferin Street, Lakeshore Boulovard and Roncesvalles Avenue.

Regardless of the actual numbers of rooming and boarding houses in Ward 2, as a form of housing they represent a relatively small proportion of the housing market, while providing shelter to a relatively large population of the Ward. The majority of that population is made up of ex-psychiatric patients. Their low income dictates the form of shelter that can be obtained while at the same time forcing the boarding home owner/operator to over-rent their facilities in order to break even or make some profit. The range of quality of shelter is almost as great as the number of boarding houses. PCLS observes that often the margin of profit is increased by decreasing maintenance of the property and/or providing the cheapest quality meals and that complaints by occupants regarding poor maintenance, fire hazards, over-crowding or poor meals are most often met with immediate eviction by the operator.

Competition for the better quality boarding houses is great. Often the result of this type of competition is that the residents who require the most stable housing environment eventually end up in the lowest quality boarding house.

The quality of the boarding house supply together with the great demand for cheap housing means that the slightest change creates havoc within the boarding house sector. PCLS provided this example to illustrate the situation:

> One Parkdale boarding home operator runs five houses. They are not the worst nor the best quality in the range that exists. The operator leases the houses from the owner. After five months of not being paid by the operator, the owner pursues legal action against the boarding home operator and obtains a Writ of Possession. For whatever reason, the operator intends to continue operating boarding homes. To this end, three different properties are obtained by the operator for the purposes of operating boarding homes. The three facilities chosen are currently licensed as boarding homes - all are currently providing housing. Their residents receive 48 hours notice to vacate the premises. Where do the people of these three properties go? The residents of the first five houses will continue to have shelter only if they are prepared to move with the boarding home operator to the three new properties. The new facilities may be even more crowded than the old.

Status of Occupants of Rooming and Boarding Houses

PCLS describes the first hurdle in advising occupants as to the determination of what laws govern their occupancy. The major question is whether or not the Landlord and Tenant Act applies. If this Act does apply then a whole code of rights, obligations and procedures comes into play. But the courts have applied a test of occupancy with the result that occupants of rooming houses do not seem to come under the protection of this Act. Rather, their occupancy seems to be considered to be that of a "licensee", not a "tenant".

However, no case to date has set out clear guidelines as to what the distinction is between a tenancy and a licence. Unfortunately, it is only by going to Court that the occupants know where they stand.

At best, one can say that an occupant of a rooming or boarding house may be covered by the Landlord and Tenant Act. Each situation must be examined on its own facts and merits.

Two obvious consequences flow from this situation. Without going to Court, occupants of rooming and boarding houses can never be entirely certain of their rights and obligations, and are thus particularly vulnerable to their landlords. Secondly, for those occupants who would appear not to be covered by the Act, very few protections exist and they are in a sense "second class citizens" compared with those having the status of tenants.

PCLS has summarized the housing problems of ex-psychiatric patients into four main problem areas: 1) lack of security of tenure, 2) lack of privacy, 3) distraint of belongings, and 4) disrepair of the premises and low quality of services provided, e.g., meals.

A full report on how the present Landlord and Tenant Act addresses each of these problems can be found in Appendix C.

Apart from the Landlord and Tenant Act certain other laws exist that affect both tenants and occupants of rooming and boarding houses. PCLS gave the following examples: municipal by-laws, the Innkeepers Act, and the common law.

Municipalities may enact by-laws which deal with such matters as standard of repair of property and, as is the case in the City of Toronto, with the licensing of rooming houses. Such by-laws give certain protections but usually the standards are minimum ones that depend on the municipality rather than an individual enforcing them. The municipality's view of when action should be taken is not always the same as the individual's.

The Innkeepers Act, R.S.O. 1980, C.2.7, is provincial legislation that gives an innkeeper, boarding house keeper, or lodging house keeper, "a lien on the goods of his guest, boarder or lodger for the value or price of any food or accommodation furnished to him or on his account". If part of the debt, amounting to at least one week's board or lodging, remains unpaid for three months then the goods can be sold.

There is also a body of common law that has developed that affects licensees and may have some relevance. The common law speaks to the issues of eviction and privacy. For example, while the common law would not grant security of tenure to licensees it at least gives them the right to "reasonable notice" prior to eviction. With regard to privacy it would allow licensees (if a fee is paid for their accommodation) to sue the owner for breach of their right to exclusive possession of their premises if the owner's intrusion could be said to breach that right. Unfortunately, this is of little practical assistance to most discharged psychiatric patients. The Court processes that would be involved are slow, cumbersome and require access to legal services which in themselves can be expensive.

Conclusion as to the Landlord and Tenant Act

PCLS has stressed that the mere inclusion of occupants of rooming and boarding houses in the Landlord and Tenant Act will not solve the problems of housing for ex-psychiatric patients. Only some of them will be able to "make it" living in housing operated in the private market by private individuals with no adjunct support services. However, it would still be a step forward to amend the Landlord and Tenant Act to make it clear that occupants of rooming and boarding houses are covered by its provisions. There is no satisfactory rationale for maintaining occupants of rooming and boarding houses in a different and secondary position vis-a-vis the "traditional" tenant.

I agree with PCLS that group homes with adjunct support services must be provided in addition to the boarding homes which do not provide support. But I am advised that legislation such as the Landlord and Tenant Act is not appropriate to govern the relationship between the occupants and the providers of supportive housing, for example, group homes. I would like to see the development of additional legislation that is appropriate to such relationships.

Recommendations:

RECOMMENDATION #7: THAT THE MINISTER OF CONSUMER AND COMMERCIAL RELATIONS BE REQUESTED TO REVIEW APPENDIX C OF THIS REPORT AND TAKE STEPS TO AMEND THE LANDLORD AND TENANT ACT SO THAT IT IS CLEAR THAT ITS PROVISIONS APPLY TO OCCUPANTS OF ROOMING AND BOARDING HOUSES.

RECOMMENDATION #8: THAT THE MINISTER OF CONSUMER AND COMMERCIAL RELATIONS BE REQUESTED TO DEVELOP PROVISIONS IN THE LANDLORD AND TENANT ACT TO DEAL WITH PROBLEMS UNIQUE TO ROOMING AND BOARDING HOUSES AS DETAILED IN APPENDIX C OF THIS REPORT, AND TO ADVISE CITY OF TORONTO COUNCIL ON HIS CONSIDERATION OF THIS MATTER BY SEPTEMBER, 1984.

RECOMMENDATION #9: THAT THE CABINET OF THE GOVERNMENT OF ONTARIO UNDERTAKE THROUGH THE ESTABLISHMENT OF AN INTERMINISTERIAL COMMITTEE, A REVIEW OF THE LEGAL STATUS OF TENANTS IN THE SUPPORTIVE HOUSING SECTOR. THIS REVIEW SHOULD BE DONE IN CONSULTATION WITH DISCHARGED PSYCHIATRIC PATIENTS, COMMUNITY WORKERS AND OTHER SERVICE PROVIDERS ABLE TO PROVIDE THE INTERMINISTERIAL COMMITTEE WITH ESSENTIAL PRACTICAL KNOWLEDGE NOT OTHERWISE AVAILABLE, WITH A VIEW TO ENSURING THAT THESE TENANTS ARE AFFORDED APPROPRIATE PROTECTION COMMENSURATE WITH THE UNIQUE AGENCY/RESIDENT RELATIONSHIP IN SUPPORTIVE HOUSING.

7. CRISIS INTERVENTION SERVICES

In the course of the Task Force examination of coordinated aftercare for the chronic psychiatrically disabled, a serious gap in services was initially brought to our attention by a representative from Nellie's Hostel for Women. In a report released in May of 1982 entitled The Role of Nellie's in Providing Psychiatric Aftercare, the rapid increase in the number of women coming to the hostel with a psychiatric history was documented. From the perspective of the people operating the hostels, a serious problem arises when a resident goes into psychiatric crisis. Hostel staff are not trained to cope, yet support from the community is often unavailable. This is especially true for hostels where children are accommodated. As a last resort, police are called, but police have limited powers under the Mental Health Act of Ontario. According to Constable Michael Fredrico of the Metropolitan Toronto Police, an officer must witness the individual acting in a bizarre fashion and must have knowledge that the individual is mentally ill before the officer has the authority to make an arrest under Section 11 of the Act. Constable Fredrico reported that the number of arrests under all relevant sections of the Act has increased by 54% over the past four years.

Both police and the Nellie's report identify considerable difficulty in arranging admission to the psychiatric wards of general hospitals for those who (in their view) require medical attention. These concerns are echoed by members of the Supportive Housing Coalition, which is in the process of examining the problem of finding appropriate care for residents who are going through crisis in the houses SHC operates. Houselink Community Homes (a member of SHC), which operates resident run supportive housing, has been advocating a crisis care location for approximately three years. Houselink's objective is, where possible, to maintain the resident in the community yet not to disrupt the normal operation of the house. In the 1981 SHC "Blueprint", a mobile crisis team and short term acute care residence was recommended (p. 37). In addition, as previously mentioned, the Metro Toronto District Health Council (MTDHC) is researching the coordination of mental health services (including crisis intervention services) and expects to release a report in May, 1984.

Preliminary results from MTDHC interviews with the psychiatry departments at the acute care general hospitals indicate that planning mental health care often takes place in isolation. A recent illustration of the consequences of this isolation may be seen in the failed attempt of the teaching hospitals to set up a common bed registry. Apparently this failure was due to a lack of trust and to the long established custom of independent hospital operation. The problem of emergency care for patients in psychiatric crisis was often viewed in terms of a bed problem, according to the MTDHC's chief researcher. Another major issue was that psychiatric residents were having to spend lengthy periods of time phoning around for beds in order to accommodate patients in crisis. If a presenting psychiatric emergency case had "recently" been cared for by a psychiatric hospital, such as Queen Street Mental Health Centre, frequently the person was sent back to the psychiatric hospital. Unfortunately this procedure does not guarantee admission and there are few alternatives once the person is refused. This problem has been perceived by a number of service providers, police and consumer groups whom we consulted.

I was pleased to attend a meeting on January 20th, 1984 called by the Hospital Council of Metropolitan Toronto (HCMT) to respond to the Task Force Preliminary Report. The numerous representatives from the general hospitals indicated a real willingness to re-examine the problems and work toward solutions. One specific suggestion was that the general hospitals make a concerted effort to set aside a certain number of beds for emergency psychiatric admissions. I hope that the HCMT will actively pursue development of coordination and I have made a recommendation to this effect.

But there is also concern about the reliance on general hospitals or psychiatric hospitals as the primary resource for discharged psychiatric patients in crisis. On page 64 of the 1981 report by the Community Resources Consultants of Toronto and the Social and Community Psychiatry Section of the Clarke Institute of Psychiatry, entitled Psychiatric Aftercare in Metropolitan Toronto, this concern was expressed as follows:

> "If aftercare services, wherever they are located, continue to be seen as hospital services, then the illness model will be reinforced and discharged patients will continue to see themselves as sick and to function in accordance with the rules of illness behaviour. In order to shift this pattern, aftercare services must espouse a rehabilitative educational philosophy and they must be seen as separate and distinct from acute care, medical-model, hospital services."

Without question there are medical psychiatric emergencies when hospitalization is the most appropriate form of treatment for the patient. It is also clear that a great deal of work remains to be done with regard to integrating the services provided by the psychiatric wards of the general hospitals into a coordinated system. I was encouragad by the meeting with the Hospital Council of Metropolitan Toronto to see that many of the general hospitals were aware of this problem.

But research shows that a free-standing short-stay residence for people in psychiatric crisis, without hospitalization, could meet some of the needs of consumers and service providers alike. ("Crisis Intervention and the Avoidance of Hospitalization" by Donald G. Langsley, from New Directions for Mental Health Services, 6. 1980 and "Soteria: An Alternative to Hospitalization for Schizophrenia", Lorne R. Mosher and Alma Menn, from New Directions for Mental Health Services, 1. 1979 and "Crossing Place: A Residential Model for Crisis Intervention" by Marilyn Kresky-Wolff et al, Hospital and Community Psychiatry, January 1984, volume 35, No.1). I am of the opinion that a free-standing short-stay residence for people in psychiatric crisis, without hospitalization, could serve to address many of the pressing service needs. This free-standing clinic would complement the role of the general hospitals, and would not be effective without a strong link to general hospitals. It is not my intention to remove the responsibility for care from the general hospitals nor to simply "add on" or duplicate yet another service; but for the chronic psychiatrically disabled living in the community and for those who provide services to them, this crisis centre can fill a genuine gap in Metro's supportive structure. The establishment of such a free-standing crisis residence in a large metropolitan centre such as ours constitutes a challenge in planning and in allocation of financial resources. I have received documentation on models developed in New York City and in Vancouver. On my behalf, Liss Jeffrey visited the four-year-old crisis intervention team in Mississauga Hospital to examine directly an autonomous crisis model within a general hospital. These models will be described before the proposal is outlined. As well, Toronto East General Hospital has provided a brief description of projects undertaken in the past five years.

1. Mobile Unit, Lincoln Community Health Center

In the southeast Bronx, New York City, the Lincoln Community Mental Health Center was established in 1963 as a result of the Mental Health Act and the creation of the Office of Economic Opportunity - both federal initiatives. The Center was responsible for the comprehensive delivery of all mental health services for a population of close to 200,000 people, of whom 60 percent were Puerto Rican, 30 percent were black, and 10 percent white. The Center employed 203 people and was organized as follows:

- in-patient department of 80 beds located at Bronx State Hospital;
- out-patient department consisting of three decentralized clinics;
- partial hospitalization service consisting of a day hospital for 25 patients and a night emergency unit with five beds for short-term crisis intervention;
- emergency services which functioned 24 hours a day, 7 days a week, with full medical and surgical backup from Lincoln Hospital and a Mobile Crisis Intervention and Suicidal Prevention Unit that provided backup on-the-spot consultations at the scene of the emergency;
- consultation and education services available to agencies and community groups for training of skills and educational support to specific programs;
- rehabilitation services offered for patients on their way back into the community;
- addiction services with a capacity for 150 patients as well as several community based drug-free treatment programs;
- liaison services, which provided precare and aftercare services for the in-patient and the partial hospitalization departments;
- training department, which offered on-the-job training for non-professionals so as to promote career development for the less skilled staff members as well as providing training opportunities for students in various helping professions.

Given the gaps in service identified by service providers in Toronto, we have specifically considered the Mobile Unit devised in the Bronx. For the purposes of the Unit, crisis was defined as "a situation that arises after ancillary services and family strengths have been depleted and the resultant is a change in the equilibrium of an individual or a family." The entire outlook of the program was oriented toward (a) the family as a unit with all attempts at assistance encompassing the entire family group; (b) the staff as part of a comprehensive setting and thus able to utilize the full facilities of the Center; and (c) in-patient hospitalization always as a last alternative to be avoided except in extreme cases.

During the course of its operation, the Unit dealt with all psychiatric emergencies encountered in that urban area. The success of the service was attributed to its ability to get involved quickly, to make appropriate consultations based on clinical and community knowledge, and to deal with people on a grass roots level. The effectiveness of non-professionals was emphasized as was the suitability of the service as an excellent training ground for community and social psychiatry.

In 1975 and 1976, the City of New York experienced serious financial insolvency and there were severe budget cuts in the City's health care delivery system. The Center was notified in June of 1975 that its annual budget of almost $4 million was to be reduced by $750,000 within one month. In June of 1976 the Center's annual budget was reduced to $.6 million. These actions forced the reduction and elimination of services geared toward primary prevention (consultation services to community agencies) and tended to strengthen the hospital-based programs.

In an analysis published in the American Journal of Psychiatry 136:1, January 1979, Dr. Pedro Ruiz was of the opinion that it would have been possible to take a more constructive approach to cost-savings, without eliminating the entire model. His proposals included:

- the enactment of appropriate legislation at all levels of government to unify services so that fewer providers delivered more services;

- centralization of administration;

- use of consortium models for service delivery;

- comprehensive planning, considering long and short-range goals, to avoid introducing measures that would only create financial problems later;

- collaboration between local and state government to define goals of mental health care delivery to ensure continuity of care and special support for prevention;

- development of effective community representation;

- catchment areas defined according to the natural locus of needs for services, not according to political or geographical boundaries;

- independent third parties with authority to monitor and evaluate ongoing programs.

2. Venture Emergency Residence, Greater Vancouver Mental Health Service

As with the Bronx model, the Greater Vancouver Mental Health Service (GVMHS) provides an extensive system of community care; Venture Emergency Services comprise one part. In a March, 1982 publication of the Mental Health Division of Health and Welfare Canada (one of a series of descriptive publications on good Canadian models of mental health service), the GVMHS was chosen "as a uniquely outstanding and successful example of an urban community mental health service designed specifically to care for the most difficult of client groups - the long-term psychiatric patient."

The Service's catchment area includes the City of Vancouver and the Township of Richmond, two municipalities with a total population of approximately 500,000. Funding for the GVMHS now comes directly from the Ministry of Health. Initial funding came through an agency supported by the Provincial Ministry of Health but with the advantage that new projects could be financed without the usual delays caused by lengthy reviews and without the requirement that monies not spent during the budget year had to revert to Treasury. Only when the GVMHS changed from an experimental project to an established agency was the funding provided in an orthodox government manner.

Venture Emergency Residence

The GVMHS operates Venture as a 10-bed short-stay emergency residence to house patients who require temporary removal from a stress situation, but for whom hospitalization would be unnecessary or undesirable. Ninety percent of the admissions to Venture are referrals from the GVMHS community care teams. Besides supervising residents, Venture staff also run an individualized day care program for a limited number of individuals and a drop-in program for individuals who have refused ongoing psychiatric help. Venture's staff also operate an after hours drop-in service, which serves approximately 10 people per evening. Food, coffee, and companionship are offered. Venture has also started a community adjustment program by setting aside two beds to accommodate male patients newly discharged from hospital whose ability to adapt to community living is in doubt.

From the outset, the GVMHS considered itself to be a 24-hour service; however, the costs of having eight staff on call proved prohibitive. Initially, the after-hours coverage was the responsibility of the community care teams in the different catchment areas. Now, all after-hours calls are routed to Venture and if necessary other staff, including an on-call psychiatrist, are brought in to attend psychiatric emergencies on the spot.

Clear negotiated agreements with other service providers are central to GVMHS's operating strategy. GVMHS has developed a written agreement with the Vancouver Police Department regarding psychiatric emergencies. If the police encounter a psychiatric emergency, they call Venture and a staff member will go to the scene to offer assistance in a car leased by Venture. In return, if Venture receives a call where there is a threat of violence, they contact police who are required to be on stand-by. If the situation turns violent, the police take over. This mobile response capability, the leased car and staff member are part of Venture's "after-hours services". The keystone of the after-hours operation is the Venture emergency telephone number, which is widely known in the community. The majority of requests for help are handled on the phone by a staff member on duty at Venture. Many of these calls are from chronic psychiatric patients who may have been in the short-stay facility at Venture. Calls regarding medication problems are quite common. Due to Venture's close proximity and working relationship with Vancouver General Hospital, on occasion police will take a psychiatric emergency from the Vancouver General Emergency Department to Venture. The Venture Mobile Car will go out in certain cases after hours. Because of budget cutbacks, there is now only one staff member available to go out in the car so the mobile response capability is more limited than at its inception. The Venture staff member is expected to respond if it is certain that there will be someone to assist him/her in the crisis situation. This crisis locale may be a boarding house, a hostel, or a long-term care facility. The staff member judges whether or not s/he can safely respond, but if it sounds like a very serious or dangerous situation, s/he calls police. In the wake of the cutbacks, Venture has a written agreement with the Vancouver Crisis Centre, which is a volunteer service operating a hotline for suicide and crisis intervention. The Crisis Centre has a "flying squad" composed of volunteers who will go out at night and attend to cases. In certain situations, Venture staff will call on the "flying squad" to respond to an emergency.

The Venture staffing arrangements are as follows: a director (currently a senior nurse), a secretary, a cook, and 12 full-time staff who work shifts i.e., four days on and two days off. Full-time employees are complemented by a number of on-call clinicians. So in effect, Venture has 13 clinical establishment positions. (letter dated July 29, 1983 from GVMHS).

Venture has close contact with other agencies such as the Metro Ambulance Service and with Vancouver General Hospital (which has the regional emergency ward). The average length of stay was seven days per in-patient and 6.2 days per crisis patient. The day patient and drop-in program provided service to a total of 2,287 "drop-ins" during the first ten months of 1983. Director of Support Services Helga Hicks reports that the 1982-83 budget was $564,570. This includes the Emergency After-Hours Services (accounting for one third of salaries) but does not include fees for psychiatrists on call to Venture. The per diem is $154.60. (see Appendix D). It is important to recognize that Venture is very selective about their admissions criteria. They draw a strong distinction between an emergency faced by a patient with psychiatric problems (e.g., food vouchers, medication problems) and a genuine psychiatric emergency. Venture will admit only the psychiatric emergency. Over 90% of the crisis cases admitted to Venture are referrals through the community care teams. The remaining patients are admitted through the after-hours route. The Director of Support Services admits that Venture has been accused of being too particular when deciding who is mentally ill and who is not. Venture will not deal with either the mildly disturbed individual, or "the very nasty and non-compliant". In this way, Venture is clear about its goals, recognizing that it cannot do everything for everyone. It is also a strong policy that only adults can be admitted to Venture. Many of the emergency cases that Venture is unable or unwilling to handle are referred to two downtown hostels.

3. Crisis Intervention Team, Mississauga Hospital

Mississauga Hospital, on the outskirts of Toronto, serves a suburban population of approximately 320,000 people. Four years ago, the Department of Social Work at the Mississauga Hospital recommended that a Crisis Team be established to support the Emergency Department. The social workers had determined that the needs of some of the people coming into the Emergency Department in states of what they called "psychosocial distress", were not being met. There had been some suicides following emergency assessment. Lakeshore Psychiatric Hospital had closed down the year before. The proposal, submitted to the Ministry of Health, Program Development Branch, initially asked for funds so that a social worker could provide consultation to doctors and nurses in the Emergency Department. Upon receipt of $60,000, they had enough money to hire three new people. The coordinator spent the first three months negotiating with the various systems, both in the Emergency Department and in the community. The negotiations focused on setting up communications, and determining mutual expectations. The patients whom the service was designed for were to be referred only by Emergency and there was to be "no dumping" of hard to handle or unwanted community agency cases. The program was to be an adult assessment referral unit, and no children were to be accepted. From the beginning, no chronic psychiatric cases that posed severe behavioural or management problems were to be, as a rule, accepted. The advantages offered by the Crisis Intervention Team were as follows:

- greater intensity of care;
- more time available to spend with clients than would be possible for medical personnel; in some cases this meant half a day;
- emphasis on coordinating efforts to handle the crisis with family and friends of the patient playing a central role;
- emphasis on referral and follow-up.

The initial client target for the three staff members was 80 per month. After the third or fourth month, this target was achieved. The clinic is currently handling 120 - 130 cases per month. They operate with three full-time social workers on staff, and three part-time staff. The operating budget is now $150,000 per year, and the Team is on permanent funding. Clinic hours are 9:00 a.m. to 10:00 p.m. Monday through Friday, and 2:00 p.m. to 10:00 p.m. on weekends. This does not include the fact that often the staff do not leave until 12:00 midnight if there is a late-breaking crisis. The Crisis Intervention Team operates autonomously from the Psychiatry Department, but has a strong liaison with the staff in the Emergency Room and with some of the community agencies. Staff turnover has been quite low over the four years of the Crisis Team's operation. Great emphasis is placed on internal morale, and the Team self-consciously operates on a democratic basis.

Of the 130 cases handled per month, an estimated 30% are psychiatric emergencies. This percentage does not include "people with emotional problems due to loss; for example, depressions based on grieving". Under its mandate, the Team does not go out and seek cases in the community, rather they take referrals from the Emergency Department. Due to the lack of facilities for ex-psychiatric patients in the community of Mississauga, there are few chronic psychiatric crises arriving at the Emergency Department. According to the Coordinator of the Crisis Intervention Team, if a chronic psychiatric patient comes into the clinic with a housing problem, generally he or she is referred to downtown Toronto.

With the psychiatric emergencies received (i.e. those not judged medically serious enough for a psychiatrist's attention), the goal of the Crisis Intervention Team is to keep the patient outside of hospital. Apparently, this goal has met with the approval of the psychiatric staff, as the psychiatrists are dealing with a more seriously ill population. The advantage of a crisis team composed of social workers is that for particular psychiatric emergencies, the patient may not need individual therapy, but rather, may need someone who is able and willing to be active and involved in solving the problem. The emphasis for the Team is on the use of friends and family in helping the patient. As the Coordinator put it succinctly, "we try to help them survive". It is interesting to note that if a patient is admitted to the psychiatric ward from the Emergency Department, the patient is referred to an in-patient psychiatric social worker. The Crisis Intervention Team does not have a role in following up these cases. Apparently, this is because they do not have the resources. It is also interesting to note that the psychiatric crises that do require the attention of the Intervention Team occur around the clock, but 30% of the cases occur before 1 p.m., another 30% before 6 p.m., and 40% thereafter. The Coordinator repeatedly stressed that the success achieved by the Mississauga Hospital Crisis Intervention Team is to a large extent dependent upon the quality of staff attracted to the job (i.e., dedication, willingness to work lengthy hours without overtime), and to the degree of coordination between the team and staff in both the Emergency Department and the outside community agencies.

The Coordinator of the Crisis Intervention Team for the Mississauga Hospital has travelled widely throughout Canada and the United States visiting a variety of crisis intervention centres. His view is that there is a chronic psychiatric population that needs very structured community settings, but these have not been provided. Because of the lack of resources, no one wants to deal with this population, so they are simply sloughed off. In general, he agreed that a free-standing clinic would be a far more appropriate way of meeting the problems of the chronic "hard-core" ex-psychiatric population. In view of the Mississauga Crisis Intervention Team's emphasis on staff quality and morale, it is understandable that he would have difficulty with the idea of one social worker or crisis person being attached to an emergency room in a general hospital. He felt that this individual might burn out quickly without the support of colleagues. "This is demanding, emotionally intensive and not necessarily rewarding work." He expressed a further concern on the question of seconding staff for a free-standing clinic. His concern was that such people might come entrenched in a particular helping modality, and thus place a greater emphasis on the passive, reflective medical approach as opposed to the action-oriented interventionist approach. In an acute psychiatric crisis, of course medical personnel are required; but people, particularly the chronic population in crisis, often do not need a reflective or medical approach. They require someone who can be innovative in trying to assist them (in other words, someone who can get involved).

4. Toronto East General Hospital

I wish to thank Mr. A. G. Prowse, the Vice-President, Hospital Services for providing me with the following summary of programs initiated by the hospital:

1. Residential Treatment Facilities:

The Hospital operates two residential treatment facilities for discharged psychiatric patients. The program serves both acute care facilities and psychiatric facilities, and provides two distinct levels of care. East Wood House is a level I (high support) unit, consisting of 10 residential beds which are staffed around the clock. This facility caters to clients requiring high support and who generally have a long history of admissions for psychiatric care.

Greenwood House is a level II (medium support) treatment unit consisting of eight residential beds staffed on a daily basis. This unit is for higher functioning adults and tends to be used as an alternative to hospitalization wherever possible.

2. The Outpatient Crisis Intervention Unit provides service in the hospital's emergency department 24 hours a day, 7 days per week. This service is staffed entirely by trained Crisis Unit Volunteers backed up by a professional Crisis Intervention Team.

3. Inpatient Crisis Intervention Unit: This unit consists of 14 inpatient beds designed for immediate crisis intervention. Patients of this unit are generally referred to other ongoing treatment programs within the department or another facility after a brief stay in hospital.

4. Native Community Crisis Intervention Team: This program is a store-front facility staffed by a professional team consisting primarily of qualified professional native counsellors designed specifically to meet the needs of native people in crisis.

In addition to these services, the Toronto East General and Orthopaedic Hospital Inc. offers an outpatient mental health clinic/day treatment program and operates a socialization program within the community.

Conclusions

While more detailed research is certainly required, in the course of the Task Force examination of crisis intervention the following conclusions have been drawn:

1. Currently there exists a serious gap in supportive services for the chronic psychiatric population. There are an estimated 1,800 Metro Toronto residents who are no longer in hospital but not yet adequately supported in the community. This gap in services has been identified repeatedly by those on the front lines: hostel staff, police, consumer groups, providers of housing and aftercare programs.

2. On the whole, the general hospitals' psychiatric departments have not assumed the responsibility for the chronic population envisioned in the deinstitutionalization program.

3. Serious reservations exist about the appropriateness of taking a medical approach to a community care model.

4. The gap in services will not be filled overnight. At least in the short-term - five to ten years - efforts to coordinate aftercare services will continue. This is particularly true in the area of housing.

5. At the same time, history has shown that the chronic psychiatric population will experience crisis periods. The chronic psychiatrically disabled have a need for and a right to support during these crises.

6. In order to achieve the hoped for transition to a more coordinated system, all providers of psychiatric aftercare will need support for their efforts, particularly those providers of housing services.

7. In addition, the public has a right to expect that mental health services in the community will be coordinated and that support in crises will be available - both in the community and, where appropriate, in the hospitals.

Recommendations

In light of the above, I am making four recommendations which I think will serve as effective catalysts in improving crisis intervention services on a realistic basis. The free-standing crisis centre is proposed only as a necessary complement to other components of a coordinated psychiatric aftercare system.

RECOMMENDATION #10: THAT THE GENERAL HOSPITALS IN THE CITY OF TORONTO SERIOUSLY CONSIDER THE ESTABLISHMENT OF CRISIS INTERVENTION TEAMS BASED ON THE MODELS THAT HAVE BEEN DEVELOPED AT THE MISSISSAUGA HOSPITAL AND THE TORONTO EAST GENERAL HOSPITAL.

RECOMMENDATION #11: THAT THE MINISTRY OF HEALTH DEVELOP WAYS TO INCREASE FUNDING FOR EXTENSION OF HOURS AT AFTERCARE SERVICES USED BY DISCHARGED PSYCHIATRIC PATIENTS IN CRISIS, SUCH AS THE SATELLITE CLINICS OF THE QUEEN STREET MENTAL HEALTH CENTRE, THE PARKDALE ACTIVITY AND RECREATION CENTRE AND SOME PROGRAMS RUN BY SELF-HELP GROUPS.

RECOMMENDATION #12: THAT THE HOSPITAL COUNCIL OF METROPOLITAN TORONTO UNDERTAKE TO DEVELOP PROPOSALS BY THE FALL OF 1984 TO PROMOTE JOINT VENTURES BETWEEN GENERAL HOSPITALS AND COMMUNITIES TO SERVE CHRONIC PSYCHIATRICALLY DISABLED PEOPLE.

RECOMMENDATION #13: THAT A TORONTO COMMUNITY CRISIS CENTRE BE SET UP ALONG THE FOLLOWING LINES:

1) In general, length of stay to be fewer than seven days. The objective is to help a person in psychiatric crisis to become stabilized sufficiently to return to the community without inappropriate hospitalization. Methods will include short-term supportive counselling; effective referral links; concrete assistance with immediate crisis related problems; access to self-help support or counselling where appropriate; medication where appropriate. Methods will not include forced medication. The expectation is of a speedy return to the community.

2) The target clients are chronic psychiatrically disabled adults in crisis who lack supportive resources. The centre is not designed for involuntary clients. Initially it is anticipated that within these parameters admission criteria must be flexible. The centre should strive to avoid a too restrictive application of "chronic psychiatrically disabled". At the same time, the target is the patients with psychiatric crises of a chronic nature - those whose needs are demonstrably neglected - and the original mandate should not be diluted.

3) A free-standing centre located in a house-form setting in downtown Toronto.

4) No more than 15 beds be available in a comfortable, non-institutional environment. There is research available to suggest that the ideal number of residents in a crisis setting may be six to ten. (Mosher and Menn, 1979)

5) The hours of operation be 7 days per week 24 hours per day, holidays and weekends included.

6) Funding from Ministry of Health, Community Health Programs Branch. Estimated start-up costs $644,800. Annual cost $500,000. (See Appendix E)

7) Crisis centre to be operated and managed by a community board responsible to the City of Toronto and the Ministry of Health. Predecessor to this board should be a group considering the details of implementation. The Ministry and the City should appoint this planning group as soon as possible and membership should include local residents, service consumers and members of the Supportive Housing Coalition Sub-committee on Crisis Care. The eventual board should include a representative from the general hospitals.

8) Mandate be reviewed after three years of operation. Evaluation to be based on the number of clients served, endorsement from psychiatric aftercare providers and consumers, staff assessment, board.

9) Quality of staff critical to effective operation. Centre staff to include medically trained and community trained mental health care workers. Modifying the Vancouver Venture House model:

   1 coordinator/director.
   6 clinical staff (registered nurses, registered
      psychiatric nurses, public health nurses, or
      psychiatric social workers.)
   6 community mental health care workers.
   1 cook.
   1 secretary.
   plus relief staff. 3 staff on duty at all times.

10) One psychiatrist on call at all times for medical emergencies, possible admission to hospital, and prescription of medication.

11) Strong links be forged with the general hospitals' emergency departments and psychiatric wards as well as case managers. Centre is intended to be free-standing, an alternative step but not isolated from hospital or community.

12) Effective referral links be established and maintained to and from community services. A central objective in early stages of the program to be liaison with potential users of the service - hostels, consumer groups, police, boarding home operators and families.

13) Part of preliminary process to include extensive training for staff with a view to gaining awareness of services available as detailed in District Health Council Inventory of Mental Health Services in Metro. Similarly, a vital early task is for crisis centre staff to educate service providers and community resource groups on the centre's role.

14) From the inception of the program a leased car and at least one staff member be available for mobile community problem intervention. As the need is reviewed, this mobile response unit could play an increasing role in the provision of emergency services and may link up to the Metro ambulance/police systems.

15) In the second year of operation, a distress line be added to the service. Initially, the 911 emergency number for referrals should be encouraged. The "hotline" seems particularly valuable in view of the Vancouver experience where many problems that can turn into emergencies - for example, uncertainty about medication - can be forestalled on the phone. Liaison with general distress lines now in operation should first be undertaken.

This proposal is an ambitious and costly undertaking. Without a doubt such an undertaking will require the utmost cooperation and goodwill on the part of many concerned groups who do not normally work together. At one extreme, the "anti-psychiatry" spokespeople disapprove of the medical aspects of the model; at the other extreme those who believe the psychiatrist is God will not be satisfied. But it is my view that a community-based crisis centre with a medical component can provide a complement to other services and meet an urgent need that is not being met now.

In no way would the establishment of a free-standing crisis clinic remove the responsibility from the general hospitals to provide service to the psychiatrically disabled. Crisis intervention teams within the hospital may be a creative response to this need as the experience of Mississauga Hospital has shown. I also heartily endorse the point made by Dr. E. W. Busse, Chairperson of the Association of General Hospital Psychiatric Services: "A comprehensive plan of action must be based on an integrated service model - combining community services and general hospital services." (Correspondence dated January 20, 1984.) In the same vein I agree with Dr. Robert Buckingham, Chairman of the Emergency Psychiatry Subcommittee of the Department of Psychiatry at the University of Toronto, when he says that the first issue that must be addressed is the need for more coordination. I am also encouraged by his comment that: "If the crisis centre is established, we would be more than willing to participate in the work of its advisory board. And, in the day-to-day work of the centre we would expect a reciprocal relationship between the teaching hospital emergency departments and the centre." It is the willingness to act to find solutions as expressed in these comments that offer some hope.

Implementation of the community crisis centre will require strong backing - political endorsement by City Council and the Provincial Cabinet, and the time and support of the many groups involved in the field of mental health care. I recommend that first steps be taken as soon as practical.

8. WORK: TOWARDS A RANGE OF OPPORTUNITIES

The three primary concerns of the Task Force have been laid out in this report as the need for: 1) supportive housing, 2) crisis intervention, and above all, 3) coordination of services to the deinstitutionalized psychiatric population (especially those with chronic disabilities). However, if our aim is to assist ex-psychiatric patients to live a full life in the community, it is clear that opportunities to find meaningful work must be addressed as well.

At the Public Hearing held in November 1983, to consider the Preliminary Report of the Task Force, many of the speakers asked the Task Force to include work issues in our Final Report. Marge Murphy, representing a group of ten service providers in the CMHA-Metro Vocational Action Committee, summed up these concerns by stressing the importance of having "as much access to work opportunities as possible for the discharged psychiatric patient."[1] It became very clear after the various deputations made to the Task Force that there is little solid information available on employment and the programs that would prepare the psychiatrically disabled for employment. In other words, placement and vocational rehabilitation services have been accorded a low priority in Toronto.

Although the Task Force was not in a position to undertake original research, I felt it was important to try to briefly outline in this chapter both the employment prospects for the psychiatrically disabled, and the current system of vocational rehabilitation. Time and again the Task Force was told that this issue is plagued by dilemmas for those who administer vocational rehabilitation programs and for those who use them. This chapter contains a brief overview of the funding, coordination and program design dilemmas as well as a summary of some positive steps recently taken to develop a range of assistance and placement options.[2]

Overview of Current Situation

Work is a normal expected activity in this society that gives a central meaning and purpose to most people's lives. Work can involve financial rewards, a sense of self-worth, contacts and relationships with others, and feelings of belonging and accomplishment. There is a great deal of evidence to show that work can play a vital role in the process of recovery for ex-psychiatric patients. Equally, spending hours of empty time without being productive has also been shown to lead to a relapse.[3]

Employment prospects are bleak for the deinstitutionalized psychiatric patient. The report "Psychiatric Aftercare in Metropolitan Toronto" found that 62% of patients discharged from hospitals were unemployed six months after discharge. While 40% of the patients in the survey were diagnosed as in need of vocational educational services, only 17% were actually referred to such services.[4] Other studies estimate that the unemployment rate for this population could be between 70 and 90%.[5] This high percentage is due in part to the persistence of serious unemployment nationally, and the consequent intense competition for jobs.

Other barriers to finding work for the ex-psychiatric patients brought to the attention of the Task Force include: negative stereotypes of the mentally ill, a loss of confidence, and either lack of previous work experience or of job finding skills.[6] In her deputation on behalf of the CMHA Vocational Action Committee, Marge Murphy told the Public Hearing that what is needed to support the former psychiatric patient in overcoming these barriers is: "A comprehensive system of work training situations, job placement services, sheltered and protected work, flexibly adapted to the capacities of the individual and staffed by persons accustomed to dealing with this population."[7]

Current Activities

The current system of vocational rehabilitation originated in the 1960s with the passage of the Federal Vocational Rehabilitation For Disabled Persons Act (1961). Together with the federal Canada Assistance Program (1966), this enabling legislation set the terms for funding of vocational rehabilitation directed at all forms of disability. After the policy of deinstitutionalization came into effect in the late 1960s, patients discharged into the community sought access to the system in greater numbers. Naturally, this has placed more pressure on the resources available.

The Federal Government is represented locally by Canada Employment Centres and programs sponsored by the Canada Employment & Immigration Department for employers hiring the "disadvantaged", which includes the psychiatrically disabled. Both the service providers and consumers who spoke to the Task Force criticized these federal government programs for sounding good in theory only but being ill-suited, in reality, to the actual needs of the psychiatrically disabled. It is a positive step toward better coordination of the federal programs that Ottawa has appointed a coordinator who will be responsible for programs that are offered to the psychiatrically disabled.

At the provincial level, four ministries share responsibility: the Ministries of Health, Community & Social Services, Labour, and Colleges and Universities. To date, Labour plays a relatively minor, but growing role in the field. Through the Handicapped Employment Program, (whose primary concerns traditionally have been with the physically disabled) Labour has the mandate to encourage employers to hire the handicapped. They have recently funded research and conferences, and share with Community & Social Services the responsibility to educate the private sector about ways they can hire the handicapped.[8]

The Ministry of Colleges and Universities is involved in the field through the funding of basic job training programs at community colleges. There are other Ministries involved in the field, such as the Secretariat for Social Development. But clearly, the Ministry of Health and the Ministry of Community and Social Services (ComSoc) are the two ministries with primary responsibility for providing vocational rehabilitation services to the psychiatrically disabled and help with employment placement.

ComSoc operates the Vocational Rehabilitation Service (VRS) which provides one-to-one career assessment and counselling for the disabled. There are 35 counsellors in Toronto, each handling 80 to 90 cases per year.[9] Gary Glassford, Social Services Supervisor of the Southwestern VRS office in Toronto, has stated that the chronic psychiatrically disabled are more difficult to assist than other disabled clients. However, Glassford points out that VRS is allowed to purchase services from a variety of outside agencies such as Goodwill and Jewish Vocational Services, in order to try to meet the needs of the psychiatric clients. ComSoc will pay up to 80% of the costs of an outside program for an approved client.

Some difficulties resulting from ComSoc's 80% funding policy for VRS approved programs were expressed to the Task Force at its public meeting in August 1983. Major Tom Sharegan from The Salvation Army pointed out that the Ministry of Health fund 100% of the vocational rehabilitation programs that it sponsors compared to the 80% level provided by ComSoc. Representatives from other service agencies told the Task Force that this difference in funding can lead to a decision not to hire less "productive" (i.e. more severely disabled) workers because the remaining 20% must come from income generated by the vocational program. These more disabled workers are thus denied employment opportunities.

The goal of VRS programs is to place clients in permanent work situations in either competitive employment or sheltered workshops. This means that VRS will accept candidates for their programs when they are "feasible", which means ready in the near future for sheltered or competitive employment. The decision as to who is feasible and who is not, is a very difficult decision often made under trying circumstances. For example, the chronic or recurring nature of many psychiatric illnesses may mean that the VRS counsellor may not consider the client ready for permanent long-term employment. But the service providers point out that the emphasis on full-time work as opposed to part-time opportunities may make placement unnecessarily difficult. Part-time opportunities are often better suited to the needs of many psychiatrically disabled people.

These problems are not unique to the Toronto area. A report on services in the Ottawa-Carleton region prepared by the Canadian Mental Health Association in 1982 noted that there were no part-time employment programs. This report concluded: "The most common inadequacy cited in the employment area by those interviewed for the Canadian Mental Health Association survey was the lack of a full range of programs."[10] Another problem that appears to be common to both Cities is overly long waiting lists. There appear to be two bottlenecks in the system - a delay in seeing a VRS counsellor, and a wait to get into the program designated as suitable for the client.[11] Gary Glassford confirmed that the waiting period may be from six to nine months to get a first appointment with a VRS counsellor. He feels that this is a problem of resources, especially a lack of sufficient numbers of counsellors to move clients along. Glassford explained the current VRS approach of in-depth individual assessment, which is of necessity time-consuming, and argues that it should not be altered simply as a means of reducing the waiting period for program placement. One frustrated service provider spoke of an 18-month waiting period from the time an appointment was requested of VRS until the time placement in a rehabilitation program was arranged. Many service providers expressed concern that psychiatric clients were deteriorating during such a length of time.

At the public meeting in August 1983, Major Tom Sharegan from The Salvation Army echoed the views of many when he described the basic problem with the system: the lack of coordination among the many provincial ministries involved in vocational rehabilitation. Part of the problem appears to be the difference in mandates between the Ministry of Health and the Ministry of Community and Social Services. Brenda Singer, Director of Progress Place, noted that the Ministry of Health historically "... was not into vocational rehabilitation programs except in the hospital; ComSoc ran the community programs, but they were not equipped to handle psychiatric clients well." With the advent of deinstitutionalization, many discharged psychiatric patients became clients of VRS. The Ministry of Health's approach seems to have been based on the policy that its mandate is to care for the ill, and therefore, work programs were funded as a form of treatment. But more recently, a greater readiness to fund more flexible community-based programs has been demonstrated by the Ministry of Health, with the advent of the Community Mental Health program and the Ministry of Health's recognition of a greater responsibility for the psychiatrically disabled outside the hospitals. I commend the Ministry of Health for funding these programs at the 100% level.

Towards a Range and Continuum of Opportunities

Both consumers and service providers told the Task Force how important it is to recognize the tremendous diversity of the psychiatrically disabled. Not only is each individual unique in terms of background and level of functioning, but each individual may go through varying stages during recovery. There was also agreement on a point made by the C.M.H.A. Vocational Action Committee: "Few people feel good without a job and purpose. Without this structure and the good feelings being productive brings, people drift downward, and relapses and depressions occur more frequently and more quickly. On the other hand, too much pressure and too high expectations cause relapses and setbacks."[12] It is important that work opportunities be available when chronic psychiatrically disabled people are ready to work and that such opportunities have various degrees of required abilities to match the abilities of various members of the community.

Service providers and consumers also shared the view that no single model to address work will suit all needs; the challenge is to develop a range of training and employment opportunities within a flexible structure. The Task Force was told that it would be useful to aim for a model similar to that proposed by the Supportive Housing Coalition in its range of housing options.[13] As Ron Ballantyne, Director of Community Resources Consultants of Toronto, pointed out to the Task Force, "Vocational rehabilitation for the psychiatrically disabled is even more complicated than the other areas, including housing." Although the model requires further exploration, consumers and service providers alike have clearly stated to the Task Force that one priority for such a model would be an emphasis on supportive, part-time, flexible work opportunities. Enthusiasm is also expressed for consumer originated projects, possibly taking the form of self-help co-ops such as the Mad Market which is operated by On Our Own. Clearly, there are gaps - such as the lack of part-time work opportunities - but I am heartened by the fact that many of the basic resources required to build a coordinated system are already in place.

Shelley Cainer of Community Resources Consultants described the components of a continuum of vocational rehabilitation services to the Task Force last August that addresses the issues of opportunity and variety:

1. Vocational Planning Services: To assess and counsel. Example: Clarke Institute of Psychiatry Rehabilitation Services.

2. Vocational Preparatory Programs: To assist clients in group settings. Example: Rehabilitation Through Education, George Brown College.

3. Short-Term Assessment and Work Adjustment Training Programs: Assessment conducted in simulated work settings. Example: Toronto General Hospital Work Assessment and Work Adjustment Program.

4. Specialized Employment Programs: To offer extra resources to clients who have a high level of functioning. Example: Canada Employment Centre, Special Needs Program.

5. Long-Term Work Activity Program and Sheltered Workshops: To serve the client who is assessed as not ready for competitive employment. Example: Salvation Army Sheltered Workshops.

6. Transitional Employment Program: To provide part-time or temporary jobs with ongoing support in the workplace. Example: CMHA Metro Transitional Employment Program.

   Psychosocial Centres: To provide work tasks that prepare club/centre members for transitional employment. Example: Progress Place.

7. Competitive Employment: To assist job-ready clients to find work.

Consumer initiated self-help co-ops as recommended by many speakers would clearly be compatible with this continuum of services.

New Directions

The Task Force has been informed of many exciting programs that are either underway or awaiting funding. These programs were designed to fill some of the perceived gaps in the continuum of services. The Vocational Action Committee's Marge Murphy described one such widely perceived gap at the November Public Hearing: "It is exceedingly important that we recognize it is no longer acceptable to refer recovering discharged chronic psychiatric patients for placement or vocational help geared to full-time employment appropriate to the needs of relatively healthy individuals."[14] The Vocational Action Committee proposes a transitional temporary or part-time job placement service for those with recurring and serious psychiatric illness: "This project would find employers who can supply shorter, long-term temporary jobs and/or part-time work and match these jobs to those who need this type of employment. The program would supply the necessary support for this group to work when and as long as they can."[15] The Vocational Action Committee did a survey of agencies to determine the need for such a placement and support effort and discovered more than 350 clients who could have benefitted from such a service. The Vocational Action Committee estimates that they could make 300 placements per year.[16] The Vocational Action

Committee suggested to the Task Force that in addition to meeting these demonstrable needs, the program they propose would be cost-effective; it would keep people from continually returning to a system designed for full-time competitive employment; and further, this program would remove certain clients from the lengthy waiting lists for full-time competitive work.[17]

The Task Force was told that three innovative projects received full-time funding from the Ministry of Health within the past year. The Trinity Square Cafe is a teahouse located on the west side of the Eaton Centre, housed in Trinity Church. This small business is run by the Rehabilitation Through Education program at George Brown College. The Trinity Square Cafe employs up to 12 part-time trainees who have had psychiatric treatment. They practice work skills on the job for four to six weeks in a supportive environment. Employees are paid a small incentive allowance.

East-Metro Vocational and Activity Centre (EVAC) is another transitional employment program, funded by the Ministry of Health. Started by the CMHA Metro, EVAC is located in Scarborough and serves the Whitby catchment area. According to EVAC Director, Sarita Bopanna, EVAC assesses former psychiatric patients (41 since June) and assists them with the development of skills and placement. To accomplish this goal, EVAC uses transitional work stations which are time-limited programs with an intensive focus on developing the client's work habits, attitudes and skills to an acceptable level. This is part-time on the job training for which the employee is paid a small wage. After preliminary negotiations initiated by EVAC, an employer agrees to supply a certain number of jobs to the agency. EVAC guarantees that the jobs will be done, by staff if necessary, and then divides the jobs among clients on a part-time basis. Generally the client is on the job for eight weeks and is paid trainee wages. Following completion of this program, EVAC attempts to place the client in a job, and provides a three-month follow-up period of support for employer and employee. The major problem for clients and service providers such as EVAC is that when the program is complete, it remains dishearteningly difficult to find full-time or part-time employment. So far, EVAC has had a certain degree of success in placing their clients. According to Ms. Bopanna, EVAC is looking for another employer who might offer transitional work stations. In addition, a staff member at EVAC continues to search for job placements. In the future, Ms. Bopanna would like to see EVAC's program expand to include a social skills training component (self-confidence and work management), an area that she feels is directly related to vocational rehabilitation.

Of the seven projects funded in the fall of 1983 by the Ministry of Health at the recommendation of the Metro Toronto District Health Council, three were innovative vocational rehabilitation programs. In addition to EVAC and the Trinity Square Cafe, the third program is operated by Progress Place in North York. Progress Place has evolved from a day treatment program into a clubhouse based on the Fountainhouse model in New York City.[18] At Progress Place the clubhouse is run by units such as clerical, maintenance and snack bar. Staff and members work together. Director Brenda Singer observes that the support provided by the clubhouse is an essential ingredient of the program which addresses the needs of the whole person. Progress Place recently started a transitional employment project where club members are placed in part-time entry level positions.

So far, Progress Place has received cooperation from some private sector companies such as Canadian Tire, and they are continuing to find more placements for their club members. These transitional employment opportunities complement the other Progress Place programs in the areas of social rehabilitation and housing. Ms. Singer would like to see further imaginative steps undertaken such as the funding of cottage industries, which might become self-sufficient. She feels that federal funds from the Canada Employment and Immigration Commission for example, could be used to help the psychiatrically disabled who are also the chronically unemployed.

Another imaginative approach under way in Toronto is the attempt to establish a central referral agency with a hotline telephone number that will try to coordinate jobs and potential employees who are disabled. The Business Advisory Commission (BAC) - a group of service providers have held a series of meetings with private sector employers who have indicated an interest in participating in such a project. Bonnie Kirsh from the Clarke Institute Work Adjustment Program is a member of the BAC and reports that the BAC would like to have their referral service in operation by the end of 1984. In Ottawa, a central referral number for job placement for all disabled groups called Line 1000 has proven to be an important element in the continuum of available services.[19]

The groups involved in the Business Advisory Commission and the Vocational Action Committee (with many members from the same agencies) have recognized that territorial rivalries must be overcome among the service providers themselves before a genuinely cooperative effort can be effective. In addition, some members of the Vocational Action Committee told the Task Force that it was necessary that consumers be represented on these organizing bodies, as is the case with the Supportive Housing Coalition. In fact, I found it noteworthy that whenever the Task Force spoke at length with service providers and consumers in the field of vocational rehabilitation and employment placement services the idea that a coalition might serve a useful purpose in this area was advanced. As the service providers and consumers have made clear, lack of coordination is a significant problem with the current system. Recent positive developments include the increased strength of the consumer groups, such as the established "On Our Own", and the new group "Looks Like Up." At the level of advocacy and leadership, there is a clear need for the presence of consumers on the various committees. It is very encouraging that many service providers seem genuinely interested in hearing from consumers. Progress Place's Brenda Singer is the former director of Ottawa's Causeway Work Centre which became the Centre for the Causeway Coalition, a lobby group. She too strongly endorses the idea of an effective local coalition.

Many service providers also stressed to the Task Force that it was important that government and the social service agencies themselves hire the psychiatrically disabled. Recent awareness in this area, particularly in the wake of the International Year of the Disabled (1981), has stimulated placement efforts at the provincial level and led to the creation of equal employment opportunity offices at the Metro and City levels.

The Task Force received favourable comments about the cooperation between The Council for Equal Employment for the Disadvantaged (C.E.E.D) - a group of social service agencies for all forms of disability - and the Ontario Civil Service Commission. Until the freeze on hiring by the Province was introduced at the end of 1981, these two groups worked closely to place disabled clients in paid jobs. Now, placement efforts continue, but are primarily directed to non-paid work stations.[30]

	1980/1	1981/2	1982/3
Candidates registered for employment	166	71	79
Attained employment (permanent, contract or temporary)	54	32	35
Candidates placed in work stations	16	21	37

At the Metro Toronto level, Belinda Morin, Director of the Equal Opportunity Program for the Disabled, stresses that Metro's employment program is not a rehabilitation program. The emphasis is on equal opportunity where disability does not prevent the candidate from performing the job. The Equal Oppertunity Program is part of the personnel function at Metro. The goal is to enforce the Ontario Human Rights Code which prohibits discrimination on the basis of psychiatric disability unless this disqualifies the candidate from performing a particular job. The

Metro Equal Opportunity office reports that the rate of placement of psychiatrically disabled in temporary jobs is: 1981 - 1; 1982 - 6; 1983 - 4.

At the City of Toronto the approach is quite similar. During the International Year of the Disabled (1981), the question of an appropriate hiring policy was raised. Following a study, the definition of the disabled was expanded to include the psychiatrically disabled. According to Maureen Spencer, a Program Consultant with the Equal Opportunity office, they do not receive many referrals from service providers because these agencies know that there is no special support available on the job for their clients. Information available shows the results at the City level: January to October 1983 - 1 permanent candidate hired, subsequently terminated; 27 temporary placements.

Recommendations

As the service providers and consumers have made clear, lack of coordination is a significant problem within the current system. However, recent innovative efforts to come up with solutions to the problem have been encouraging. In the spirit of building a better, more coordinated system to foster a greater range of work opportunities for the psychiatrically disabled the Task Force makes the following recommendations:

RECOMMENDATION #14: THAT THE CABINET OF THE GOVERNMENT OF ONTARIO ESTABLISH AN INTERMINISTERIAL COMMITTEE AT THE SENIOR LEVEL TO COORDINATE PROVINCIAL ACTIONS, AND TO PROMOTE COOPERATION BETWEEN THE PROVINCIAL AND FEDERAL GOVERNMENTS IN VOCATIONAL REHABILITATION PROGRAM DEVELOPMENT.

RECOMMENDATION #15: THAT THE INTERMINISTERIAL COMMITTEE, AS ONE OF ITS FIRST ACTIONS, COMMISSION AN INDEPENDENTLY-CONDUCTED STUDY OF EMPLOYMENT NEEDS AND OPPORTUNITIES OF THE PSYCHIATRICALLY DISABLED IN ORDER TO DEVELOP A PRACTICAL MODEL FOR A CONTINUUM OF SERVICES IN THIS FIELD.

RECOMMENDATION #16: THAT THE INTERMINISTERIAL COMMITTEE AND THE EQUAL OPPORTUNITY PROGRAM OFFICES OF METROPOLITAN TORONTO AND THE CITY OF TORONTO REVIEW THEIR RESPECTIVE PERSONNEL POLICIES TO PUT IN PLACE MECHANISMS THAT WILL ACCELERATE HIRING OF THE PSYCHIATRICALLY DISABLED IN THE PUBLIC AND PRIVATE SECTORS.

RECOMMENDATION #17: THAT THE MINISTRY OF COMMUNITY AND SOCIAL SERVICES REDEFINE "EMPLOYMENT" TO INCLUDE PART-TIME FLEXIBLE WORK ON AN EQUAL BASIS WITH FULL-TIME PERMANENT WORK.

FOOTNOTES

1. Transcript of the Task Force Public Hearing held November 30, 1983, p.17. In addition to speaking on behalf of the CMHA Vocational Rehabilitation Committee, Marge Murphy is assistant director of Rehabilitation Services at the Clarke Institute of Psychiatry.

2. In addition to the Advisory Committee, thanks are due to the following individuals for their speedy response to our request for information:

   Ron Ballantyne, C.R.C.T.
   Bernie Berger, Jewish Vocational Services
   Sarita Bopanna, E.V.A.C.
   Shelley Cainer, C.R.C.T.
   Brenda Duclos, Ontario Civil Service Commission
   Barbara Earl, Handicapped Employment Program
   Gary Glassford, ComSoc
   Bonnie Kirsh, C.E.E.D.
   Layne Mellanby, George Brown College
   Belinda Morin, Metropolitan Toronto
   Marge Murphy, Clarke Institute of Psychiatry
   Connie Schwenger, Clarke Institute of Psychiatry
   Brenda Singer, Progress Place
   Maureen Spencer, City of Toronto

3. Psychiatric Aftercare in Metropolitan Toronto, p. 67.

4. Ibid.

5. Community Resources Consultants, "Employment and the Psychiatrically Disabled", unpublished paper, 1983.

6. Ibid. see especially pages 3 and 4.

7. Transcript of the Task Force Public Hearing, p. 17.

8. The Ontario Ministry of Labour Handicapped Employment Program (H.E.P.) funded the Community Resources Consultants paper referred to in footnote #5, "Employment and the Psychiatrically Disabled". In addition, CRCT prepared an inventory, "Vocational Rehabilitation Resources Serving the Psychiatric Client", December, 1983, also with Ministry of Labour funding.

9. Conversation with Gary Glassford, Social Services Supervisor of Southwestern Toronto VRS office. The percentage of cases that are primarily psychiatric disabilities is not available.

10. "A Matter of Urgency: The Psychiatrically Disabled in the Ottawa-Carleton Community", by Anne Louise Parker and Louise

Rosborough, Canadian Mental Health Association, Ottawa-Carleton Branch, 1982, p. 51.

11. Ibid, p. 48.

12. CMHA Vocational Action Committee, Minutes of meeting held October 17, 1983.

13. Supportive Housing Coalition, Community Housing for Consumers of Mental Health Services in Metropolitan Toronto, Position paper, September, 1981.

14. Transcript of the Public Hearing, p.17.

15. Ibid.

16. Temporary Employment Program, CMHA Vocational Action Committee submission to the Ministry of Health, Programs Division, January 13, 1984, p.2.

17. Ibid.

18. Preliminary Meeting of the Advisory Committee, p.6.

19. See footnote #10, p.137.

20. Conversation with Brenda Duclos, Ontario Civil Service Commission.

9. COORDINATION OF AFTERCARE SERVICES

The term "aftercare services" encompasses a rather intimidating array of organizations with different structures and different definitions and different methodology. In 1983 the Thames Valley District Health Council completed a comprehensive study of adult mental health services delivery for that area of Ontario. While many of their conclusions may not be appropriate in the context of Toronto, the description developed by the Task Force of common denominators of aftercare support has been most useful (taken from Appendix III of the report entitled, "Status of Adult Mental Health Services Delivery, Thames Valley District Health Council, 1982/1983.")

1. Standard Discharge Planning Process to begin in the hospital or psychiatric facility prior to actual discharge.

2. Aftercare/Caseworker to be assigned to each patient prior to discharge, to remain available to the client until able to manage on his/her own or until only periodic maintenance check-ups are required within the home environment.

3. Graduated Housing, another term for a range of supportive housing, should be immediately available. To quote the Thames Valley Report at page 3: "as seen by data and review, clients worry over basic shelter, food and income needs and this leads to depression and re-admission to hospital."

4. Crisis Team Intervention available on a 24-hour (seven days a week) basis should be provided for clients "acting out" and be available to clients, hospitals, landlords and families of the chronically disabled people who live at home.

5. Case Management Committees available to individual case workers to ensure frequent ongoing assessment aimed at rehabilitation, consistency of follow-up, providing solutions for hard-to-serve people who may still tend to fall between the gaps in service.

6. Coordinating Committee for Hospitals, Community Agencies and Aftercare Workers with the mandate to ensure community cooperation and coordination to meet the needs of discharged patients in an effective way.

7. Vocation Training, Including "Sheltered Workshops" to make appropriate workshop programs available to serve members of the chronic psychiatric population as well as the developmentally handicapped (mentally retarded).

8. Re-assessment of Staffing Needs in order to ensure a holistic approach to treatment and programming, not just from a medical model sense. In preparation for this, hospitals and community agencies will need to assess their roles in aftercare and it will mean coordination with a view to an extension of role mandates using available staff wherever possible.

9. Communication and Interaction Among Hospitals, Psychiatrists and Community General Practitioners to be developed for each individual patient case to ensure that those working outside the hospital setting are well informed and that confidentiality is ensured.

10. Central Placement Service to be used to place clients properly within the supportive housing available and in accordance with the discharge plan.

11. Public Awareness Program to be developed by the coordinating committee mentioned in point 6, with the cooperation of organizations in the community such as advocacy groups working in cooperation with service clubs, to hold educational seminars in places such as schools, shopping malls and during Mental Health Week.

This section of the report has not been organized strictly along the lines of the 11 points developed above because the situation in Toronto is by no means identical to the Thames Valley Region. However, with these 11 points as the "big picture" let us now turn to an examination of the situation in Toronto.

The study "Psychiatric Aftercare in Metropolitan Toronto" pointed out that the most common form of aftercare available to the discharged psychiatric patient was chemotherapy. Concerns have been expressed to the Task Force about the lack of alternatives to medication. At the Public Hearing Annick Aubert described the situation for her tenant, who is a former psychiatric patient: "I know very well that he goes every month to collect a piece of paper that has been signed the day before, prepared by a clerk, ... he goes to the pharmacist who fills it and he brings it home. I have been trying to speak with his doctor to ask about maybe vacations from the drug or reduced dosages, because I cannot feel, even though I have no medical knowledge, that a person who is now living happily at home needs as much medication as someone who is wandering the streets of Toronto."

This question of medication of deinstitutionalized psychiatric patients deserves further attention. Perhaps the type of "holistic" system proposed by the Thames Valley District Health Council may provide some solutions to the problems expressed to the Task Force. I would agree with the conclusion of the "Psychiatric Aftercare in Metropolitan Toronto" report when it said: "With the addition of a more comprehensive array of aftercare services providing both support and rehabilitation, the need for higher doses and longer term administration of antipsychotic drugs may be reduced." (p.65)

In view of the above concerns the Task Force makes the following recommendations:

RECOMMENDATION #18: THE MINISTRY OF HEALTH SHOULD COMMISSION AN INDEPENDENT RESEARCH PROJECT INTO THE USE OF MEDICATION TO MAINTAIN PATIENTS IN THE COMMUNITY. RESEARCH CONCERNS SHOULD INCLUDE THE APPROPRIATENESS OF SUCH MEDICATION; EFFECTS ON FUNCTIONING; POSSIBLE SIDE EFFECTS; THE INFORMATION PROVIDED TO THE USERS; AND THE SYSTEM OF MONITORING LONG-TERM EFFECTS.

RECOMMENDATION #19: ALL PROFESSIONALS CONCERNED WITH AFTERCARE SERVICE DELIVERY - PHARMACISTS, PSYCHIATRISTS, GENERAL PHYSICIANS, CASE WORKERS AND OTHERS - SHOULD REVIEW THEIR POLICIES AND PROCEDURES AS REGARDS THE MONITORING OF PATIENTS' FUNCTIONING ON LONG-TERM PSYCHIATRIC MEDICATION. PROFESSIONAL ASSOCIATIONS SHOULD CONSIDER SUCH QUESTIONS AS ONGOING MEDICAL EDUCATION, THE NECESSITY FOR PROVIDING INFORMATION TO PATIENTS, AND THE POSSIBILITY OF A SYSTEM OF PEER REVIEW.

Reference has already been made to the extensive report prepared for the Parkdale Working Group by the Clarke Institute of Psychiatry Consulting Group entitled "Systems Coordination for Psychiatric Services in Toronto," June, 1983, which suggests a pilot project for coordination of aftercare services in the western area of the City of Toronto, including the Parkdale area. (For further background information see the Psychiatric Aftercare Service section of chapter 5). This report deals with the 11 points listed above, but in the context of the City of Toronto and Metropolitan Toronto. Considerable discussion has ensued since the introduction of the report in the summer of 1983, and the Parkdale Working Group has recently decided to accept the general principles of the Report, but to begin coordination efforts with an immediate, client-centered project. As a result, the Parkdale Working Group held a final meeting at the end of November and the Coordinating Committee for the Western Health Area was established in its place. This Committee will determine policy for the pilot project which will link discharged chronic patients in the Western Health area with community mental health programs.

Mental Health Program Placement Services

This is the title of the pilot project mentioned above. The primary function of the new service will be to link discharged patients to community programs through a single channel. In addition, the service will be designed to provide: 1) a central registry of program data for the Western Health Area, 2) a data base which can be used for future planning, and 3) a mechanism for exchange of inter-agency information.

Having reviewed the proposal for the Mental Health Program Placement Service, I am favourably impressed with several aspects of the proposal and pleased by the decision to move quickly in developing the service.

Recommendation

Having had the benefit of the multidisciplinary expertise represented on my Advisory Committee, I am further convinced that successful coordination of aftercare services in the City and Metropolitan Toronto is a necessary but complex process that has to be developed in stages. To be successful, this coordination service must not only be supported and respected by health and social services agencies but it must be recognized in the community and by clients as a necessary means of achieving effective and efficient use of resources. For this reason I recommend as follows:

RECOMMENDATION #20: THAT THE MENTAL HEALTH PROGRAM PLACEMENT SERVICE BE ENDORSED IN PRINCIPLE BY THE CITY OF TORONTO, AND THAT COUNCIL REQUEST THAT THE INITIAL STAGE OF THE SERVICE MUST BE THAT OF EXTENSIVE CONSULTATION WITH THE AGENCIES, INCLUDING HOSPITALS AND THE QUEEN STREET MENTAL HEALTH CENTRE, WITH A PARTICULAR EMPHASIS BEING PLACED ON CONSULTING WITH CONSUMERS OF MENTAL HEALTH SERVICES IN THE PARKDALE AREA.

RECOMMENDATION #21: THAT CITY COUNCIL AND THE LOCAL BOARD OF HEALTH DEVELOP THE MEANS BY WHICH THE CITY OF TORONTO COULD "TWIN" WITH THE CITY OF ROME, ITALY, IN THE AREA OF SERVICES TO DISCHARGED PSYCHIATRIC PATIENTS.

10. ATTITUDES: BARRIERS TO COMMUNITY MENTAL HEALTH

One of the major barriers to community support for psychiatrically disabled is attitude - everyone's attitude toward an issue that arouses archaic dread and fears of a person who is "not normal". As we discussed in the History Section, perspectives toward mental health and illness have changed - but still these attitudes exist. Dear and Taylor, in the introduction to their valuable study on public attitudes toward group homes for the psychiatrically disabled in Toronto, point out that:

> "Public attitudes to the mentally ill and to the facilities which serve them are of fundamental importance for the success of deinstitutionalized care in two ways. First, from the perspective of the ex-psychiatric patients, the attitudes of residents in neighbourhoods where facilities are located are of great importance in determining their social integration in the community. The potential therapeutic value of being part of a "normal" environment can be seriously weakened or entirely lost if local residents demonstrate rejecting attitudes. ... The second major reason why public attitudes toward the mentally ill are important relates to planning. Deinstitutionalization presents government and social service agencies with a very difficult task, mainly to provide a network of facilities adequate to meet the needs of patients discharged from hospital and of those who would previously have been sent to hospital-based institutions. In many instances, the decrease in the number of institutionalized patients and the consequent increase in community care clients has been so rapid that the demand for community facilities has inevitably outreached the supply. The gap has been partially met, but there remains the need to establish many more purposely created facilities in the community."

On this same question, then Health Minister, Larry Grossman commented in an April 1983 speech: "A recent Ministry study shows that the more that Ontarians know about the needs, the benefits, and the successes of community based programs for people challenged with mental health difficulties, the more they support that."

The news media play a significant role in spreading this knowledge and shaping these public attitudes. In general the media in Toronto have been very responsible. Often the media have served as voices for the voiceless - highlighting abuses and ensuring that the plight of the mentally disabled remains on the political and social agenda. We commend the media for their actions. At the same time, a socially responsible media should continue to educate its members about the attempted solutions to the obvious problems in the mental health field. While the failings of the system, invisible abuses, must be reported, the dramatic case of abuse should not overwhelm attention to the positive (often slow and incremental) process of change.

We also applaud the joint efforts of the Ontario Ministry of Health and the Candian Mental Health Association (Ontario Division) for their $1.5 million communications campaign for public awareness. More needs to be done in this regard, but it is heartening to see public education addressed in a sophisticated and direct manner.

Educational seminars - such as the workshops on group homes sponsored by the City of Toronto and the Secretariat for Social Development - are also a step in the right direction. In addition, many volunteer organizations have contributed tirelessly to the goal of public education. We thank all these groups for their efforts and trust that they will continue. The ex-psychiatric advocates clearly have an instrumental role to play in raising public awareness. All these attempts to reach the public are ongoing and important, as are the many research undertakings that have been mentioned throughout this report.

Still, the question of "not on our street" remains. The Task Force will make no formal recommendations in the area of public education other than to applaud the diverse efforts under way and to urge sincerely that concerned citizens and the politicians elected to serve them recognize the importance of this issue and act out of moral conscience. There are sincere people who believe in community mental health care, yet continue to insist "not on our street." We view this attitude as misguided and firmly maintain that these fears can only be allayed by the continued successful integration into the community of caring environments for the psychiatrically disabled. It is critical in this regard that all areas of the community share this responsibility. Actions speak louder than the words of a few - and we urge concerned citizens and officials to keep this firmly in mind when weathering the inevitable storms.

I would like now to return to a point first made in my introduction to this report. If we, as citizens of Toronto, are to be proud of our City, we must face an undeniable reality. The greatness of our City is not judged only on its architectural monuments, clean streets or efficient subways. The true measure of a civilization rests on how it treats its vulnerable members. It is on that, we too are being judged. I strongly urge my fellow citizens to do what is right -- not what seems, in the short run -- politically expedient.

APPENDIX A: PROTOTYPE CONTRACT FOR CONTRACT AFTERCARE PROJECT

Introduction

The draft prototype contract provides for the physical rehabilitation of a boarding house in which ex-psychiatric patients reside and the provision of basic services to the residents. Although funding which enables the physical rehabilitation to take place will be provided by the Province, the parties to the contract are the City, and the Owner/Operator of the boarding house. Schedules 'A' and 'B' of the contract contain the physical and service standards respectively. The proposed standards draw upon the experiences and recommendations of a number of regulatory bodies and groups, adapted to the City of Toronto situation. A survey of the varying standards and their sources is contained in Appendix B. This contract was prepared to give a concrete example of the Contract Aftercare Project. Undoubtedly, changes will have to be made as the project actually develops.

The implementation mechanism for the draft contract requires further development by the Implementation Committee. The Implementation Committee must develop guidelines that will address such matters as the initial choice of an appropriate boarding house for contractual purposes. This choice should be partially governed by the proportion of residents who are psychiatrically disabled. During the initial phases of this pilot project the Implementation Committee will be asked to give prior consideration to houses where the owner and operator are the same person, so as to minimize the number of parties to the contract and thereby facilitate implementation. However, the contract has been drafted to allow for the possibility of the owner and operator being separate parties, where appropriate.

In consideration of the City's approving the Owner and or Operator as parties to the contract and thereby receiving the benefit of assistance toward physical rehabilitation of the property in question, the Owner/Operator will be expected to covenant and agree that the City shall have an option to purchase the property under terms and conditions to be developed. The purpose of such an arrangement is to ensure that, once improved, the property continues to be used as an upgraded residence for low-income people, a majority of whom will be discharged psychiatric patients.

In the event that the property is sold, provision should be made in the contract for the property to continue to be operated in accordance with C.A.P. standards. The term of the contract shall be for at least five years subject to an annual review by the City of Toronto for contract compliance.

This Agreement made this ______ day of _______ 19__.

By and Among:

THE CORPORATION OF THE CITY OF TORONTO
Hereinafter called "the City"

- and - ____,

OWNER OF A BOARDING HOUSE LOCATED AT __________
Hereinafter called "the Owner"

- and - ____,

OPERATOR OF A BOARDING HOUSE LOCATED AT __________
Hereinafter called "the Operator"

WHEREAS the City is authorized pursuant to ____________________ to enter into agreements with ____________________ respecting the physical rehabilitation of housing and the provision of services;

WHEREAS ____________________ is the Owner of premises located at ______________________________, which is a licensed boarding house pursuant to the City's Rooming House By-law 502-80 as amended from time to time, hereinafter referred to as "the House";

WHEREAS ____________________ is the Operator of the House, in that he/she is responsible for the day to day operation of the House;

WHEREAS it is the intention of the City to assist the Owner and Operator by providing funding to physically rehabilitate the house and to provide services to the residents accommodated in the House;

WHEREAS the Owner and Operator have agreed to the physical rehabilitation of the House and the provision of services to the residents accommodated in the House;

Now THEREFORE THIS AGREEMENT THAT in consideration of the mutual covenants and agreements herein contained, and subject to the terms and conditions hereinafter set forth, the parties hereby agree as follows:

1. **Financial Disclosure**

The Owner and Operator covenant that a full and complete disclosure has been made relating to all financial aspects of the operation of the House, including but not limited to:

(a) all security interests attached to the House;

(b) the costs and revenues associated with the day to day operation of the House.

2. **Payment of Funds by the City**

The City will contribute the sum of ________ for the purpose of the physical rehabilitation of the House to meet the standards as set out in Schedule 'A' and as required pursuant to section 3 of this Agreement.

3. **Compliance with Laws**

The Owner and Operator will ensure that the House complies with:

(a) any rule, regulation, direction or order of the Local Board of Health and any direction or order of the Medical Officer of Health;

(b) every applicable by-law of the City and the Municipality of Metropolitan Toronto;

(c) every applicable statute and regulation of the Provincial and Federal Governments.

4. **Authorized Capacity**

The Owner and Operator covenant that the House will be used to accommodate no more than ____ residents, or as authorized from time to time by the City in writing to the Owner and Operator of the House.

5. **Financial Records and Reports**

5.1 The Owner will maintain proper financial records of books of account in accordance with standard accounting procedures respecting the physical rehabilitation of the House.

5.2 The Operator will maintain proper financial records of books of account in accordance with standard accounting procedures respecting services provided to residents, and records and reports as set out in Schedule 'B'.

6. Inspections

The Owner and Operator will permit the City to enter and inspect the House and observe and evaluate services and all records kept by the Owner and Operator in respect to the House at all reasonable times and at such intervals as the City deems advisable.

7. Indemnification

The Owner and Operator covenants to take full responsibility for the residents admitted to the House and covenants to save harmless and indemnify the City from all actions, claims, suits or demands of any kind whatsoever arising out of or caused by the acts or omissions of the Owner or the Operator.

8. Amendment

Schedule 'A' and 'B', which are incorporated into this agreement, may be amended from time to time by the City upon __ days written notice to the Owner and Operator.

9. Termination

This Agreement will be in force from _____ day of _________ 19 __, until it is superceded or replaced by a subsequent Agreement or until:

(a) the City at any time terminates this Agreement for a breach of any of the terms of this Agreement;

(b) the City, the Owner, or the Operator terminate this Agreement upon ___ days written notice to all parties.

SCHEDULE 'A'

PHYSICAL STANDARDS

Water Supply

1. The House shall be provided with a water supply system that maintains an adequate supply of potable and hot water:

   (a) which conforms in quality to the Drinking Water Objectives of the Ontario Ministry of the Environment, February, 1978 edition; and the Guidelines for Canadian Drinking Water Quality, 1978;

   (b) which can provide at least litres (gallons) of hot water per Resident per day;

   (c) of at least .562 kilogrammes pressure per square centimetre (8 pounds per square inch), when a fixture is in use;

   (d) the temperature of the water serving all bathtubs, showers and hand basins used by occupants shall not exceed 49 degrees Centigrade (120 degrees Fahrenheit) and shall be controlled by a device, inaccessible to the occupants, that regulates the temperature.

Toilet Facilities

2. (a) Toilet facilities shall be provided in at least the following ratios:

      (i) for an authorized capacity of four to seven Residents: one washbasin, one flush toilet, and one bathtub or shower;

      (ii) for an authorized capacity of a fraction of seven Residents beyond the first seven: one wash basin and one flush toilet;

      (iii) for an authorized capacity of each additional seven Residents beyond the first seven: one washbasin, one flush toilet, and one bathtub or shower.

   (b) Each bathtub and toilet shall have one grab bar adjacent to the facility;

   (c) The bottom of each bathtub shall be furnished with non-skid material;

(d) A rack on which to hang towels and face cloths shall be provided for each resident;

(e) Bathrooms, toilet and shower rooms shall be provided with doors and shall have locks of a type that can be readily released from the outside in an emergency.

Bedrooms

3. (a) The floor area of each bedroom shall meet the following ratios:

(i) 9 square metres (96.878 square feet) for a bedroom occupied by a single Resident,

(ii) 7 square metres (75.35 square feet) for each additional Resident occupying a bedroom;

(b) A bedroom for Residents shall not be occupied for living or sleeping purposes by more than three Residents;

(c) Every bed for a Resident shall be a minimum width of 91.44 centimetres (36 inches);

(d) Every Resident shall be provided with a minimum of .68 cubic metres (24 cubic feet) of storage space in his bedroom. The storage space shall be provided with a lock and openable only by the individual Resident utilizing the facility.

Dining Room

4. (a) A dining area or areas shall be provided with the following minimum floor area:

(i) 1.858 square metres (20 square feet) of floor space for each Resident, or

(ii) 11.148 square metres, (120 square feet) whichever is greater;

(b) The dining area need not be provided in the house if the Owner or Operator provides meals in some other facility under his direct control, and the provision of such meals is included as part of the rental paid by the Resident of the boarding house.

Common Area

5. (a) A sitting room or common area shall be provided which is separate from any other area in the house and is maintained for the use of the Residents of the house;

(b) The minimum total space for the sitting room shall be:

  (i) calculated at the rate of 139 square metres (15 square feet) of floor space for each Resident, or

  (ii) 11.148 square metres (120 square feet) whichever is greater.

Lighting

6. The following minimum levels of illumination shall be provided:

(a) 161.45 lux (15 foot-candles) continuous lighting in all corridors, halls, at floor level;

(b) 215.28 lux (20 foot-candles) continuous lighting in all stairways, landings;

(c) (i) 107.64 lux (10 foot-candles) in all bedrooms
  (ii) 376.74 lux (35 foot-candles) at bed reading position;

(d) 1076.4 lux (100 foot-candles) for drug cabinets;

(e) (i) 322.92 lux (30 foot-candles) in general kitchen
  (ii) 538.2 lux (50 foot-candles) on range tops and kitchen work surfaces
  (iii) 753.48 lux (70 foot-candles) on kitchen sink;

(f) 322.92 lux (30 foot-candles) in washrooms;

(g) 322.92 lux (30 foot-candles) in game rooms;

(h) 107.64 lux (10 foot-candles) plus local lighting in living room;

(i) 322.92 lux (30 foot-candles) in laundry;

(j) Lighting in other areas of the House shall comply with Illuminating Engineering Society Standards;

(k) 10.76 lux (1 foot-candle) as emergency lighting for all means of egress in Houses which are required to have a fire alarm system.

Ventilation

7. Every room shall be adequately ventilated by natural or mechanical means and shall be so designed and installed that it meets the requirements of sections 6.2 and 9.33 of the Ontario Building Code. Such ventilation shall be installed

only after plans have been approved and a building permit issued, by the Chief Building Official.

8. A bedroom for one or more Residents shall:

   (a) have one or more windows to the outside that,

      (i) except where another means of ventilation is provided, can be opened to provide an open area equal to 5% of the floor area of the room,

      (ii) is not less in total area than 10% of the floor area of the room,

      (iii) is screened from May 1 to October 31,

   (b) not be part of a lobby, hallway, passageway, closet, bathroom, stairway, basement, attic, kitchen, storage room, boiler room, laundry room, activity room, utility room, chapel, sitting room, administrative office, or resident examination room.

General Safety

9. The following shall be provided:

   (a) handrails, of a type that will ensure the safety of Residents, installed on each side of every stairway that is wider than 111.76 cm (44"); on at least one side of each stairway that is 111.76 cm (44"), or less, in width; and on the open side of each stairway or landing, with the top of each handrail not less than 76.2 cm (30") nor more than 106.68 cm (42") above the finished floor or stair level;

   (c) non-skid finishes and coverings on floors and stairways; and

   (d) balustrades on the open sides of every stairway, landing, balcony, raised porch, or roof to which Residents have access; no opening in any such balustrade shall be more than 10.16 cm (4") wide.

Fire Safety

10. The House shall comply with Reg. 730-81, (The Fire Code under the Fire Marshals Act).

House Cleaning

11. (a) The House shall be maintained in a clean and sanitary condition;

(b) without limiting the generality of sub-section 11(a), maintenance includes:

   (i) the sweeping and washing of the floors of all kitchens, dining rooms, bathrooms, and common passageways twice every week;

   (ii) the sweeping and washing of the floors of all bedrooms once every week;

   (iii) the washing of the inside and outside of all windows and window coverings including drapes and blinds once every six months.

Kitchen

12. The kitchen shall comply with R.R.O. 1980, Reg. 840, (The Food Premises Regulations under the Public Health Act).

Letter Box

13. Every Resident shall have the use of a letter box which is identified by the Resident's name and located so as to permit regular mail delivery by the employees of the Canada Post Corporation.

SCHEDULE B

SERVICE STANDARDS

Staffing

1. At least the Operator or one adult employee of the Operator shall be on duty in the House twenty-four hours a day.

Nutrition

2. (a) The Operator shall ensure that Residents are served daily with food that is of sufficient quality, quantity and nutritional value to meet the recommended daily nutritional intake as specified by the Federal Department of Health and Welfare;

   (b) The Operator shall post a menu once a week in the dining area or in a conspicuous place, detailing the food to be provided at each particular meal during the forthcoming week.

Linen and Towels

3. (a) Sufficient clean towels, face cloths and bed linen shall be provided for use of the Residents, and a supply of such linen shall be on hand at all times in the House;

   (b) In any event, towels, face cloths and bed linen shall be changed at least once a week;

   (c) All bed linen shall be changed when the occupancy of a bed changes.

Toilet Articles

4. The Operator shall provide each Resident with sufficient toilet tissue and handsoap for his or her needs.

Control of Drugs

5. The Operator shall ensure that

   (a) all prescription drugs are kept in one or more locked drug cabinets;

   (b) all prescription drugs are made available only to those Residents for whom they have been prescribed, as directed by the physician;

(c) the drug cabinet(s) shall contain a detailed list of contents which is kept up to date on a daily basis by the operator, and is available for inspection upon request.

Records and Reports

6. The Operator shall maintain:

   (a) An up-to-date, alphabetical list of Residents showing for each Resident, his or her name, sex, age and date of admission.

   (b) A separate file shall be maintained for each Resident, showing at least his or her name, sex, age; date of admission and discharge or death; name, address and telephone number of nearest relative; brief medical history; particulars of each accident suffered by the Resident.

Medical Care

7. (a) Each Resident or,

   (i) his or her next of kin or legal representative, as the case may be; or

   (ii) where the Resident, his or her next of kin or legal representative are unable so to do, the Operator

   shall retain a physician to attend the Resident and provide emergency medical care.

   (b) The Operator shall make arrangements for a physician, or substitute physician, to be on call to provide emergency services when a Resident's physician is not available.

Nursing Care

8. Whenever the physician mentioned in section 7 determines that a Resident requires emergency nursing care or "Home Care Services," the Operator shall allow such nursing care or "Home Care Services" to be given to that Resident.

Programming

9. The operator shall ensure access to service agencies recognized by the Implementation Committee and funded for the provision of aftercare programs to residents who choose to receive such services on the premises.

APPENDIX B: A COMPARISON OF PHYSICAL AND PERSONAL CARE STANDARDS IN REGULATING BOARDING HOMES

INTRODUCTION

Because of the wide variance of standards among regulatory bodies in Ontario, the following sources have been surveyed to develop an overview of alternative physical and personal care standards that could be applied to boarding homes in which ex-psychiatric patients reside:

(a) The City of Toronto's Housing By-law, No. 73-68, (hereinafter the "Housing By-law").

(b) Other existing legislation such as the City of Toronto's Zoning By-law No. 20623 (hereinafter the "Zoning By-law") and the Ontario Building Code.

(c) The City of Hamilton's Second Level Lodging House License By-law, consolidation of By-laws 80-259 and 81-93 (hereinafter the "Hamilton By-law").

(d) Guidelines for Resthomes, Lodging Houses, Group Homes, originally issued by the Ministry of Health in February of 1980, and re-issued in December of 1980 (hereinafter the "Ministry Guidelines").

(e) Report of the Housing Sub-Committee of the Parkdale Working Group on Housing Proposals for Discharged Psychiatric Patients, June 24, 1983 (hereinafter the "Parkdale Working Group Report").

I PHYSICAL STANDARDS

1. Water Supply

(a) Housing By-law s.25(9):

(9) An adequate supply of potable water shall be available at all times in all parts of every dwelling, subject to the exceptions provided in section 30.

(c) Hamilton By-law s.6(a):

Every house shall be provided with a water supply system that maintains the following:

(a) An adequate supply of potable and of hot water:

(i) which conforms in quality to the Drinking Water Objectives of the Ontario Ministry of the Environment, February, 1978 edition; and the Guidelines for Canadian Drinking Water Quality, 1978;

(ii) which can provide at least 227.303 litres (50 gallons) per Resident and employee of the Operator, per day;

(iii) of at least .562 kilogrammes pressure per square centimeter (8 pounds per square inch), when a fixture is in use;

(iv) the temperature of the water serving all bathtubs, showers and hand basins used by Residents shall not exceed 49 degrees Centigrade (120 degrees Fahrenheit) and shall be controlled by a device, inaccessible to the Residents, that regulates the temperature".

(d) Ministry Guidelines s.3:

Similar to Hamilton by-law.

(e) Parkdale Working Group Report:

5. Hot Water. Each boarding home shall provide an adequate supply of hot water so that each occupant may take a bath or shower each day (the Sub-Committee had difficulty with this provision, and is of the opinion that 'adequacy' should be defined).

2. Toilet Facilities

(i) Number of Facilities:

(a) Housing By-law s.25:

(2) At least one water closet in good working order that is connected to the drainage system for the dwelling shall be accessible to and available for each 10 or fewer persons occupying every dwelling.

(3) At least one bathtub or shower or combination bathtub and shower that is

  (a) in good working order,
  (b) served with hot and cold running water, and
  (c) connected to the drainage system for the dwelling

shall be accessible to and available for all persons occupying every dwelling unit.

(5) Subject to subsection (6), a washbasin that is in good working order, served with hot and cold running water and connected to the drainage system for the dwelling shall be located in every room that contains a water closet or a urinal and such a washbasin shall be accessible to and available for all persons in a dwelling.

(6) Notwithstanding subsection (5) where a dwelling contains not more than 3 dwelling units, the washbasin therein referred may be located in a room adjoining the room that contains a water closet or a urinal.

(b) Zoning By-law:

Boarding homes in R2, R3, R4, and R4A districts are required to have toilets, washbasins and baths or showers on the basis of one each for every six occupants.

(c) Hamilton By-law s.16:

(3) Toilet facilities shall be provided in at least the following ratios:

  (a) for an authorized capacity of four to seven Residents: one washbasin, one flush toilet, and one bathtub or shower;

  (b) for an authorized capacity of a fraction of seven Residents beyond the first seven: one washbasin and one flush toilet;

  (c) for an authorized capacity of each additional seven Residents beyond the first seven: one washbasin, one flush toilet, and one bathtub or shower.

(d) Ministry Guidelines s.13(i):

(i) Toilet facilities shall be provided in the following ratio

(a) 1 w.c./1 w.h.l. per 8 occupants
(b) 1 tub or shower per 8 occupants

(e) Parkdale Working Group Report:

4. Bathtub or Shower. Each boarding house shall contain one bathtub for the occupants up to the first six persons permitted, thereafter a bathtub or shower shall be provided for each additional ten persons permitted. Each bathtub shall be fitted with a tight-fitting stopper to prevent leakage of water.

(ii) Privacy and Location of Toilet Facilities:

(a) Housing By-law s.25:

(4) A water closet or a urinal in a dwelling shall be located only within a separate bathroom or toilet room.

(7) Every bathroom and toilet room in a dwelling shall

(a) be located within the main building that forms part of the dwelling,
(b) have provisions for privacy, and
(c) where the bathroom or toilet room is used or is intended to be used by more than 1 roomer or boarder or by the occupants of more than 1 dwelling unit, have an entrance from a common passageway, hallway, corridor or other space used in common by the occupants of the dwelling.

(8) No person shall store or prepare food in a room that contains a water closet or a urinal.

(c) Hamilton By-law s.161:

Similar to Housing By-law, also cannot "consume" food in room that contains a water closet.

(d) Ministry Guidelines s.13:

Same as Hamilton By-law.

(iii) Other Requirement:

(c) Hamilton By-law s.16,13,22(b):

16. (1) No toilet room or bathroom shall be within, or open directly into, any dining room, kitchen, pantry, food preparation room or storage room.

(4) Bathrooms, toilets and shower rooms shall be provided with doors and shall not have locks unless they are of a type that can be readily released from the outside in an emergency.

(5) One bathroom, toilet and shower room shall be of a type that is suitable for use by persons confined to wheelchairs, where such persons are to be admitted as Residents.

(6) A small stepping stool shall be available for use with each toilet and bathtub.

(7) The bottom of each bathtub shall be furnished with non-skid material.

13. A rack on which to hang towels and face cloth shall be provided for each Resident.

22. (b) For each bathtub and each toilet, at least one grab bar or similar device of a type that will ensure the safety of Residents.

(d) Ministry Guidelines s.13:

Similar to Hamilton By-law.

3. Bedrooms

(i) Size

(a) Housing By-law s.31(3),(4),(5), and s.S.34(1):

Sleeping Use Prohibited

31. (3) Where a room in a dwelling,

(a) is less than 6 feet 6 inches in width, or (498-80),
(b) has a floor area of less than 65 square feet (498-80),

no person shall use or permit the use of the room for sleeping purposes.

Floor Area Computation:

(4) Where a room or part of a room in a dwelling does not exceed 4 feet 6 inches in height, the floor area under a ceiling that is not more than 4 feet 6 inches above the floor shall not be counted in computing the floor area of the room for the purpose of subsection (3). (498-80)

Low Ceiling Deemed Non-habitable:

(5) For the purposes of this section, a room that is less than 7 feet in height over more than one-half of the floor area shall be deemed to be a non-habitable room. (bedrooms are habitable rooms), s.2(5)

34. (1) Where a room in a dwelling is used for sleeping purposes by two or more persons simultaneously, the total number of persons using the room for sleeping purposes shall not exceed the floor area of _____.

(b) Zoning By-law:

No rooms shall be let in Boarding homes located in R2, R3, R4 or R4A districts unless the area of the bedroom is 9 square metres for a single occupant or 7 square metres for each one of two or more occupants.

(b) Ontario Building Code:

Main bedroom area:

9.5.6.1(1) Except as provided in Article 9.5.6.3. at least one bedroom in every dwelling unit shall have,

(a) where built-in cabinets are not provided, a minimum floor area of 105 sq.ft.; or

(b) where built-in cabinets are provided, a minimum floor area of 95 sq. ft.

(2) Except for buildings designed and constructed in accordance with CSA Standard Z-

240.2.1-1979, the minimum dimension of the bedroom referred to in Sentence (1) shall be at least eight feet, ten inches.

Other bedroom areas:

9.5.6.2.(1) Except as provided in Article 9.5.6.3., each additional bedroom shall have,

(a) where built-in cabinets are not provided, a minimum floor area of 75 sq.ft.; or

(b) except for buildings designed and constructed in accordance with CSA Standard Z-240.2.1-1979, where built-in cabinets are provided, a minimum floor area of sixty-five feet.

(2) The minimum dimension within the area of a bedroom referred to in Sentence (1) shall be at least 6 ft. 6 in.

Combination bedroom areas:

9.5.6.3. Bedroom spaces in combination with other spaces shall have at least 45 sq.ft. of floor area and have no dimension less than 6 ft. 6 in. within the required area.

(c) Hamilton By-law s.7:

7. (a) A bedroom for a Resident or Residents in a House established before October 1, 1980, shall provide a minimum of 16.8 cubic metres (600 cubic feet) of air space and 6.96 square metres (75 square feet) of floor space for each Resident of the age of 16 years or over;

(b) A bedroom for a Resident or Residents in a House constructed, renovated, added to or altered on or after October 1, 1980, shall provide a minimum exclusive of the space provided for built-in or portable clothes closets, of

(i) 10.22 square metres (110 square feet) of floor space in a single-bed unit, provided that this area may be reduced to 9.30 square metres (100 square feet) where the House provides a living room and a dining area(s),

(ii) 16.72 square metres (180 square feet) of floor space in a two-bed unit,

(iii) 25.08 square metres (270 square feet) of floor space in a three-bed unit, and

(iv) 29.73 square metres (320 square feet) of floor space in a four-bed unit,

for each Resident of the age of 16 years or over;

(d) Ministry Guidelines s.4(ii):

(ii) Each bedroom shall provide a minimum of 600 cu. ft. (16.99 cu. metres) of air space and 75 sq. ft. (6.968 sq. metres) of floor space per resident. In determining the area to be used for sleeping purposes, no account shall be taken of areas used for dining, sitting, recreation, food preparation, storage or laundry purposes, or that area of the residence defined in this guideline as a cellar.

(e) Parkdale Working Group Report:

5. A bedroom for Residents shall not be occupied for living or sleeping purposes by more than three Residents.

(ii) Bed Standards:

(c) Hamilton By-law s.8,10:

4. A bedroom for more than one Resident shall be furnished so that all beds are at least 91 metres (3 feet) apart.

10. Every bed for a Resident shall be a minimum width of 91.44 centimetres (36 inches).

(d) Ministry Guidelines s.4(iii):

Similar to Hamilton by-law.

(iii) Bedroom Clothes Closet:

(c) Hamilton By-law s.12:

12. A clothes closet for each Resident shall be provided in his bedroom.

(d) Ministry Guidelines s.5(iii):

Similar to Hamilton By-law.

(e) Parkdale Working Group Report:

Every bedroom shall contain storage facilities such as a cupboard or a wardrobe, so that each resident has a minimum of 24 cubic feet of storage space.

The storage facility shall be provided with a lock and operable only by the individual occupant.

4. Dining Room

(b) Ontario Building Code:

9.5.4.1.(1) A dining space in combination with other space shall have a minimum floor area of 85 sq.ft.

(2) A dining room not combined with other space shall have a minimum area of 75 sq.ft.

9.5.4.2. Except as permitted in Article 9.5.4.3., a dining room or space combined with other space shall have no dimension less than 7 ft. 6 in. within the required area measured between wall faces or a wall face and a built-in cabinet or appliance.

9.5.4.3. When a required dining area is provided in a kitchen or serves a bachelor dwelling unit, the minimum dimension of such space may be reduced to 5 ft. 6 in.

(c) Hamilton By-law s.14:

14. A dining area or areas shall be provided, with a minimum of 1.85 square metres (20 square feet) per Resident and accommodating at one time 50% of the authorized capacity of the House.

(d) Ministry Guidelines s.7:

Similar to Hamilton By-law.

(e) Parkdale Working Group Report:

2. Public Spaces. Each boarding house shall contain a dining room having an area not less than ten square feet times the number of the occupants permitted in the boarding house, but in any case not less than 120 sq. ft.

Notwithstanding the requirements of No. 2 above, the dining area need not be provided within the boarding house if the owner or operator provides meals in some other facility under his direct control, and the provision of such meals is included as part of the rental paid by the occupant of the boarding house.

5. Common Area

(c) Hamilton By-law s.15:

SITTING ROOM(S)

15. (1) A sitting room or rooms shall be provided.

(2) The minimum total space for the sitting rooms shall be:

(i) calculated at the rate of 1.39 square metres (15 square feet) of floor space for each Resident, or

(ii) be 11.148 square metres (120 square feet),

whichever is greater.

(d) Ministry Guideline s.6:

Similar to Hamilton By-law.

(e) Parkdale Working Group Report:

3. Common or Recreational Area. Each boarding house shall have an area separate from and in addition to the dining area which is maintained exclusively for the use of the occupants permitted in the boarding house, having an area not less than five square feet times the number of persons occupying the boarding house, but in any case not less than 120 sq. ft.

6. Lighting

(a) Housing By-law s.28,29:

28. (4) Adequate lighting equipment shall be provided and maintained in good working order at all times in every

(a) stairway,
(b) hall,
(c) bathroom,

(d) shower room,
(e) toilet room,
(f) basement or cellar,
(g) laundry room,
(h) furnace room,
(i) similar non-habitable work room, and
(j) kitchen

in a dwelling.

29. (8) Every storage room and every underground garage in a multiple occupancy building shall be illuminated by natural or artificial means on a level of illumination which averaged over 100 square feet of floor area and then at floor level shall not be less than 3 foot candles. (498-80)

(9) Every public and service area in a multiple occupancy dwelling other than a storage room or underground garage covered by sub-section (8) of this section shall be illuminated by natural or artificial means and the level of illumination measured at floor level equidistant from the light source shall not be less than the following: (498-80)

Room or Space	Candles
Service Rooms and Laundry Area	20
Public Water Closet Rooms	10
Public Corridors and Stairways	10
Service Hallways and Stairways	5
Recreation Rooms	10

(b) Ontario Building Code:

Illumination levels

3.2.8.1.(1) Every exit, public corridor, corridor providing access to exit for the public or serving patients' bedrooms or classrooms shall be equipped to provide illumination to an average level of at least 10 ft. candles at floor level and at all points such as angles and intersections at changes of level where there are stairs or ramps.

(2) The average level of illumination in rooms and spaces used by the public shall be in accordance with Table 3.2.8.A.

(3) For the purpose of establishing the average level of illumination, at least one measurement of intensity of illumination shall be made for every 100 sq. ft. of floor area at the floor level.

TABLE 3.2.8.A.

Forming Part of Sentence 3.2.8.1(2)

Room or Space	Footcandles
Storage rooms	5
Service rooms and laundry areas	20
Storage garages	5
Public water closet rooms	10
Stairways	10
Service hallways	5
Recreation rooms	10
Column 1	2

Emergency lighting

3.2.8.2.(1) Emergency lighting shall be provided to average levels of at least 1 ft. candle at floor or tread level in,

(a) exits and corridors used by the public where such exits and corridors are below grade or are windowless;

(b) the following parts of buildings required by Subsection 3.2.4. to have a fire alarm system,

(i) exits,

(ii) corridors used by the public,

(iii) principal routes providing access to exit in an open floor area,

(iv) corridors serving patients' bedrooms, and

(v) corridors serving classrooms;

(c) underground walkways;

(d) covered malls; and

(e) floor areas or parts thereof where the public may congregate in,

(i) Group A, Division 1 occupancies, and

(ii) Group A, Division 2 and 3 occupancies having an occupant load of 60 persons or more.

Emergency power

(2) An emergency power supply shall be provided to maintain the emergency lighting required by this Subsection from a power source such as batteries or generators that will continue to supply power in the event that the regular power supply to the building is interrupted and be so designed and installed that upon failure of the regular power it will assume the electrical load automatically for a period of,

(a) 2-hrs. for all buildings within the scope of Subsection 3.2.6.;

(b) 1-hr. for buildings of Group B major occupancy classification that are not within the scope of Subsection 3.2.6.; and

(c) 1/2-hr. for buildings of all other occupancies.

(3) Where an emergency power generator is supplied from an energy source outside of the building, provision shall be made to ensure its operation in the event of an emergency.

(c) Hamilton By-law s.19:

19. The following minimum levels of illumination shall be provided:

(1) 161.45 lux (15 foot-candles) continuous lighting in all corridors, halls, at floor level;

(2) 215.28 lux (20 foot-candles) continuous lighting in all stairways, landings;

(3) (a) 107.64 lux (10 foot-candles) in all bedrooms
    (b) 376.74 lux (35 foot-candles) at bed reading position;

(4) 1076.4 lux (100 foot-candles) for drug cabinets;

(5) (a) 322.92 lux (30 foot-candles) in general kitchen
    (b) 538.2 lux (50 foot-candles) on range tops and kitchen work surfaces
    (c) 753.48 lux (70 foot-candles) on kitchen sink;

(6) 322.92 lux (30 foot-candles) in washrooms;

(7) 322.92 lux (30 foot-candles) in game rooms;

(8) 107.64 lux (10 foot-candles) plus local lighting in living room;

(9) 322.92 lux (30 foot-candles) in laundry;

(10) Lighting in other areas of the House shall comply with Illuminating Engineering Society Standards.

(11) 10.76 lux (1 foot-candle) as emergency lighting for all means of egress in Houses which are required to have a fire alarm system.

(d) Ministry Guidelines s.9:

A minimum level of lighting shall be maintained throughout the home which will enable the residents to carry out their various activities comfortably, safely and without visual fatigue.

Explanatory Notes

The following are recommended minimum lighting intensities related to general lighting:

i) Public halls, corridors, stairways, landings, (measured at floor level or tread) - 10 ft. candle (107.64 lux)

ii) Bathroom, toilet room (measured at 30" (76.2 cm.) above floor level) - 30 ft. candle (322.92 lux)

iii)	Kitchens (measured at 30" (76.2 cm.) above floor level)	-	50 ft. candle (538.2 lux)

7. **Temperature**

(a) **Housing By-law** s.23a:

23a. Every dwelling shall between the 15th day of September in each year and the 1st day of June of the following year be provided with heat so that a minimum temperature of 70 degrees Fahrenheit (21 degrees Celsius) is maintained in each dwelling unit, except that where the occupant of the dwelling can regulate the temperature within his own dwelling unit, the minimum temperature does not apply. (500-80)

(c) **Hamilton By-law** s.20:

From September 15 until May 31, and at all other times when heating may be reasonably necessary for the preservation of health, the temperature of all rooms and halls shall be maintained at not less than 20 degrees Centigrade (70 degrees Fahrenheit).

(d) **Ministry Guidelines** s.10:

A minimum of 21 degrees C (70 degrees F) shall be maintained at all times.

Explanatory Notes

For the purposes of this section, temperature readings shall be measured at a distance of 3' (91.44 cm.) or more from the exterior walls and at a height of 2' (60.96 cm.) above the floor level.

8. **Ventilation**

(a) **Housing By-law** s.28:

(5) (a) Every habitable room, bathroom, shower room, toilet room, garbage or refuse room, laundry room, locker and storage room and all parts of a dwelling shall be provided with adequate natural or artificial means of ventilation; (498-80)

(b) The minimum ventilation to be provided for rooms in a dwelling shall be as follows: (498-80)

Minimum Ventilation Requirements

	Location	Minimum Unobstructed Area
Within Dwelling Units	Bathrooms or water closet rooms	1 sq. ft.
	Unfinished basement space	0.2 % of the floor area
	Dining rooms, living rooms, bedrooms, kitchens, combined rooms, dens, recreation rooms and all other finished rooms	3 sq. ft.
	Bathrooms or water closet rooms	1 sq. ft. per water closet
Other than within Dwelling Units	Laundry rooms, kitchens, recreation rooms	4 % of the floor area
	Corridors, storage rooms and similar public rooms or spaces	0.2 % of the floor area

(6) Where any system of mechanical ventilation is provided in any room in a dwelling, it shall be

(a) capable of completely changing the air in the room at least once per hour, and

(b) maintained in good repair and working order at all times.

(c) room air conditioners should be equipped so as to prevent condensation drainage on entrance areas, sidewalks and walkways. (498-80)

(7) All enclosed spaces within a dwelling shall be adequately ventilated, and access of sufficient size to permit entry shall be provided thereto and fitted with a door or panel to enclose the opening.

(b) Ontario Building Code:

Section 6.2 provides extensive regulations regarding ventilation systems.

(c) Hamilton By-law s.9, s.21:

s.21 Every room shall be adequately ventilated by natural or mechanical means and shall be so designed and installed that it meets the requirements of sections 6.2 and 9.33 of the Ontario Building Code. Such ventilation shall be installed only after plans have been approved and a building permit issued, by the Chief Building Official.

s.9 A bedroom for one or more Residents shall

(a) have one or more windows to the outside that,

(i) except where another means of ventilation is provided, can be opened to provide an open area equal to 5% of the floor area of the room,

(ii) is not less in total area than 10% of the floor area of the room,

(iii) is screened from May 1 to October 31,

(b) not be part of a lobby, hallway, passageway, closet, bathroom, stairway, basement, attic, kitchen, storage room, boiler room, laundry room, activity room, utility room, chapel, sitting room, administrative office, or resident examination room.

(d) Ministry Guidelines s.8:

Similar to Hamilton By-law s.9, with the following addition:

Where mechanical ventilation is provided, the following rates will generally be adequate for removing excess heat, humidity and odours:

i)	Kitchen	15	air changes p.hr.
ii)	Bathroom and toilet rooom	8	-do-
iii)	Family, recreation and laundry rooms...	6	-do-

9. General Safety

(a) Housing By-law s.19(3):

19. (1) Every stairway, balcony or porch in, on or appurtenant to a dwelling shall be maintained

- (a) in good repair
- (b) free from
  - (i) holes
  - (ii) cracks
  - (iii) excessive wear and warping, and
  - (iv) other defects that are accident hazards.

(2) Without restricting the generality of subsection (1) the maintenance includes

- (a) repairing or replacing treads, risers or floors that show excessive wear or are broken, warped or loose,
- (b) repairing, renewing or supporting structural members that are rotted, deteriorated or loose
- (c) painting,

(3) Every open side of a stairway, flat roof to which access may be gained through a doorway, terrace, balcony, porch, landing or stairwell shall have a rigid guardrail not less than 3 feet high with an intermediate rail, or balustrade not less than 3 feet high, in good repair firmly attached so as to provide reasonable protection against accident or injury.

- (a) where the vertical rise between the base of the stairway and the top of the stairway exceeds 4 feet, or
- (b) where the flat roof, terrace, veranda, porch landing or stairwell
  - (i) is more than 2 feet above the ground, floor or other horizontal plane below, and
  - (ii) can be used by any person who is in, on or at the dwelling.

(4) Every stairway that does not require a guardrail or balustrade under subsection (3) shall have a rigid handrail not less than 32 inches high and not more than 36 inches high in good repair on at least one side of the stairway firmly attached so as to provide

reasonable support for persons using the stairway. (498-80)

(b) Ontario Building Code:

9.8.7.1. Except as permitted in Articles 9.8.7.2. and 9.8.7.3., a handrail shall be provided on at least 1 side of stairs less than 44 in. in width, and on 2 sides of stairs 44 in. in width or greater.

9.8.7.2. Handrails are not required for stairs within a dwelling unit that have fewer than 3 risers.

9.8.7.3. Only 1 handrail is required on exterior stairs more than 44 in. in width and having 3 or more risers provided such stairs serve not more than 1 dwelling unit.

9.8.7.4. Handrails on stairways shall be located between 32 and 36 in. measured vertically above a line drawn through the outside edges of the stair nosings.

9.8.7.5. A clearance of at least 1 1/2 in. shall be provided between each handrail and the wall to which it is fastened.

9.8.7.6. Handrails shall be so constructed that there will be no obstruction on or above them to break a handhold.

9.8.7.7. Handrails and stair stringers shall not project more than 3 1/2-in. into the required width of stairway.

9.8.7.8. Where ramps are used in lieu of stairs, the handrail requirements for stairs in Article 9.8.7.1., and Articles 9.8.7.3. to 9.8.7.7. shall apply where the gradient exceeds 1 in 10.

(c) Hamilton By-law s.22:

22(2) The following shall be provided:

(a) handrails, of a type that will ensure the safety of Residents, installed on each side of every stairway that is wider than 111.76 cm (44"); on at least one side of each stairway that is 111.76 cm (44"), or less, in width; and on the open side of each stairway or landing, with the top of each handrail not less than 76.2 cm (30") nor more than 106.68 cm (42") above the finished floor or stair level;

(c) non-skid finishes and coverings on floors and stairways; and

(d) balustrades on the open sides of every stairway, landing, balcony, raised porch, or roof to which Residents have access; no opening in any such balustrade shall be more than 10.16 cm (4") wide.

(d) Ministry Guidelines s.11:

Similar to Housing By-law and Hamilton By-law.

10. Fire Safety

(a) Housing By-law s.18a,29a,29b:

The by-law provides specific standards relating to fire escapes and fire alarm systems

(b) The Fire Code, Reg. 730-81 under the Fire Marshal's Act, provides extensive regulations to promote fire safety.

(c) Hamilton By-law s.23,24:

The by-law provides extensive regulations which exceed the requirements of The Fire Code.

(d) Ministry Guidelines s.12:

i) All rest homes shall be required to maintain fire safety standards as specified in reg. 24 and 25, Regulation 437 Homes for Special Care.

ii) Each home shall be provided with an approved fire extinguisher on each floor.

iii) Every operator shall ensure that the home is inspected on an annual basis by the local fire authority.

11. Refuse Disposal:

(a) Housing By-law s.9:

9. All garbage, rubbish and other debris from a dwelling shall be promptly stored in regulation

receptacles and made available for removal in accordance with the provisions of By-law No. 20298 of the Corporation, as amended.

Note: By-law No. 20298 defines a regulation receptacle as a "properly covered watertight, metal container of circular design, having a capacity of not more than two cubic feet."

(c) Hamilton By-law s.18:

18. (1) Rubbish and garbage shall be stored in receptacles which are:

(a) insect and rodent proof;
(b) watertight;
(c) provided with a tight-fitting cover;
(d) kept clean.

(2) Ashes shall be stored in a metal container which has a tight-fitting cover.

(d) Ministry Guidelines s.14:

Similar to Hamilton By-law.

12. Cleanliness

(a) Housing By-law s.29:

29. (3) Every

(a) passageway
(b) hallway
(c) corridor
(d) entrance
(e) lobby
(f) means of egress
(g) living room
(h) dining room
(i) recreation room
(j) kitchen
(k) bathroom
(l) shower room
(m) toilet room
(n) other area (413-74)

used in common by the occupants of a multiple occupancy dwelling shall be maintained in a clean and sanitary condition.

(4) Without limiting the generality of sub-section (3), the maintenance includes:

(a) regular cleaning of the floors and walls;
(b) covering the floors with a durable material that is free from cracks, holes or other defects that retain dirt or are health or accident hazards;
(c) covering the walls with a durable material that is resistant to cracking, scratching or breaking or alternatively regularly painting or decorating so as to provide a finished surface which can be easily cleaned, and painting or decorating the ceilings. (413-74)

(c) Hamilton By-law s.17:

17. The House shall be kept clean and sanitary.

(d) Ministry Guidelines s.2:

All premises should be maintained in a sanitary and safe condition to the satisfaction of the Medical Officer of Health.

(e) Parkdale Working Group Report:

Cleanliness. The floors of all kitchens, dining rooms, bathrooms, common rooms and common passageways shall be swept and washed daily. The floors of all bedrooms and other habitable areas shall be swept daily and washed at least once per week.

13. Window Maintenance

(e) Parkdale Working Group Report:

6. Windows and Drapes - All windows in a boarding house shall be provided with drapes or blinds and all windows shall be cleaned inside and out every six months, and the window coverings including drapes and blinds shall be kept in a clean condition and washed periodically to maintain them in that condition.

14. Letter Box

(e) Parkdale Working Group Report:

5. Letter Box. Each boarding house to contain a letter box for each occupant permitted, in the front of premises on which the name of the individual occupant is posted.

II PERSONAL CARE STANDARDS

1. Nutritional Care

(c) Hamilton By-law s.34:

The operator shall ensure that the Residents are served daily with sufficient food of good quality and adequate nutritional and caloric value.

(d) Ministry Guidelines s.15:

Similar to the Hamilton By-law.

(e) Parkdale Working Group Report:

3. Menu. The owner or operator shall post in the dining area on a weekly basis, a menu detailing the food to be served at each individual meal during that particular week. Where meals are provided in some other place, other than the boarding home, a menu shall be posted in the boarding house in a conspicuous place.

4. Nutrition. A standard for balanced quantity and quality of food, be authorized by a dietitian appointed by the regulating body.

2. Linen and Towels

(c) Hamilton By-law s.11:

11. (1) Sufficient clean towels, face cloths and bed linen shall be provided for use of the Residents, and a supply of such linen shall be on hand at all times in the House.

(2) In any event, towels, face cloths and bed linen shall be changed at least once a week.

(d) Ministry Guidelines s.5, s.13:

Similar to the Hamilton By-law.

(e) Parkdale working Group Report:

1. Beds and Bedding. The owner or operator shall provide a bed for each occupant permitted in a sleeping room. Such bed shall be provided with a mattress and pillow and shall have two sheets and two blankets, and a pillow slip. The sheets and pillow slip shall be washed once per week and the blankets washed once per month. All bedding shall be changed by the owner or operator when the occupancy of the bed changes.

2. Provisions of Bathing. The owner or operator shall provide each occupant with a bath towel once per week. The owner or operator shall also provide each occupant with sufficient toilet tissue and hand soap for their individual needs.

3. Control of Drugs

(c) Hamilton By-law s.33:

33. The operator shall ensure that all prescription drugs:

    (1) are kept in one or more locked drug cabinets,

    (2) are made available only to those Residents for whom they have been prescribed, as directed by the physician.

(d) Ministry Guidelines s.16:

Similar to the Hamilton By-law.

(e) Parkdale Working Group Report:

7. Medicine Cabinet. Each operator or owner shall provide a medicine cabinet of sufficient dimensions to store medication given to him for safekeeping by the occupants of the boarding house. The cabinet shall be locked and the key kept in the possession of the owner or operator. The cabinet shall also contain a detailed list of the contents which is kept up to date on a daily basis by the owner or operator, and is available for inspection by an inspection agency upon request.

Other Personal Care Standards

The standards provided by the Hamilton By-law and the Ministry Guidelines are similar with regard to the following matters:

- Admission of Residents
- Medical Care
- Nursing Care
- Kitchen
- Operators' and Employees' Qualifications
- Guidance and Supervision by Staff
- Records and Reports
- Inspection of the Boarding Home

APPENDIX C: LEGAL ANALYSIS - PARKDALE COMMUNITY LEGAL SERVICES

Introduction to the Problem

The City of Toronto has 698 licensed rooming and boarding houses and 330 unlicensed rooming and boarding houses including properties where an application for a license is being processed (Report of City of Toronto Department of Buildings & Inspections, January 11, 1983). In Ward 2, the Parkdale area, there are 95 licensed rooming houses and 49 that are known to be unlicensed. The breakdown by City wards shows that Ward 2 ranks fourth in the number of rooming houses in both categories for which statistics are available. It is of particular interest to us to note that Ward 2 ranks fourth, since our own caseload reflects a great number of problems in this area of housing. One wonders about the enormity of the problems found in those wards ranking above Ward 2. It is likely that the "South Parkdale By-law", By-law 67-78, has, since its enactment in January of 1978, had the effect of limiting the number of new licensed boarding houses in the Ward as it prohibits a property's conversion to a boarding or lodging house as a legal land use in the area bounded by Queen Street, Dufferin Street, Lakeshore Boulevard and Roncesvalles Avenue.

Regardless of the actual numbers of rooming and boarding houses in Ward 2, as a form of housing they represent a relatively small proportion of the housing market, while providing shelter to a relatively large population of the Ward. The majority of that population is made up of ex-psychiatric patients. Their low income dictates the form of shelter that can be obtained while at the same time forcing the boarding home owner/operator to over-rent their facilities in order to break even or make some profit. The range of quality of shelter is almost as great as the number of boarding houses. Often the margin of profit is increased by decreasing maintenance of the property and/or providing the cheapest quality meals. Complaints by occupants regarding poor maintenance, fire hazards, over-crowding or poor meals are most often met with immediate eviction by the operator.

Competition for the better quality boarding houses is great. The outcome of this type of competition is that the residents who require the most stable housing environment eventually end up in the lowest quality boarding house.

The quality of the boarding house supply together with the great demand for cheap housing means that the slightest change creates havoc within the boarding house sector. Perhaps an example best illustrates the situation:

One Parkdale boarding home operator runs five houses. They are not the worst nor the best quality in the range that exists. The operator leases the houses from the owner. After five months of not being paid by the operator, the owner pursues legal action against the boarding home operator and obtains a Writ of Possession. For whatever reason, the operator intends to continue operating boarding homes. To this end, three different properties are obtained by the operator for the purposes of operating boarding homes. The three facilities chosen are currently licensed as boarding homes - all are currently providing housing. Their residents receive 48 hours notice to vacate the premises. Where do the people of these three properties go? The residents of the first five houses will continue to have shelter only if they are prepared to move with the boarding home operator to the three new properties. The new facilities may be even more crowded than the old.

Status of Occupants of Rooming and Boarding Houses

In attempting to advise occupants of a rooming or boarding house as to their rights when faced with the situation described above - or any situation - the first hurdle is to establish what laws govern their occupancy. The major question is whether or not the Landlord and Tenant Act applies. If this Act does apply then a whole code of rights, obligations and procedures comes into play.

The Landlord and Tenant Act defines tenant as including "lessee, occupant, sub-tenant, undertenant, and his and their assigns and legal representives". Residential premises are defined as "any premises used or intended for use for residential purposes" and "land intended and used as a site for a mobile home used for residential purposes, whether or not the landlord also supplies the mobile home". The Landlord and Tenant Act applies to tenancies of residential premises. It would seem to be clear that those persons living in rooming and boarding houses are indeed persons who meet both the definition of "tenant" and "residential premises" and, therefore, the Landlord and Tenant Act ought to apply to them.

However, this is not the case. The Courts have decided that, for the Landlord and Tenant Act to apply, the "occupancy" must be such as meets the "traditional test" of what constitutes a landlord and tenant relationship. If such test is not met then the occupancy will be that of a licensee not a tenant, and the Landlord and Tenant Act will not apply. Unfortunately, the law as to what this "traditional test" is, is most unclear. The criteria have ranged from that of exclusive possession and control, to the intention of the parties, and more recently to the nature and quality of the occupation. To date, no case has set out clear guidelines as to what the distinction is between a tenancy and a licence, but the cases have indicated that an occupant of a rooming and boarding house does not necessarily meet this test. Unfortunately, it is only by going to Court that the occupants know where they stand.

At best, one can say that an occupant of a rooming or boarding house may be covered by the Landlord and Tenant Act. Each situation must be examined on its own facts and merits. The Final Report of the Mayor's Action Task Force on Discharged Psychiatric Patients will contain a memorandum canvassing the caselaw in this area.

Two obvious consequences flow from this situation. Without going to Court, occupants of rooming and boarding houses can never be entirely certain of their rights and obligations, and are thus particularly vulnerable to their landlords. Secondly, for those occupants who would appear not to be covered by the Act, very few protections exist and they are in a sense "second class citizens" compared with those having the status of tenants.

Our experience with the housing problems of ex-psychiatric patients indicates that there appear to be four main problem areas: a) lack of security of tenure, b) lack of privacy, c) distraint of belongings, and d) disrepair of the premises and quality of services provided, e.g., meals.

The present Landlord and Tenant Act addresses each of these problems as follows:

(a) Security of Tenure

Since 1975, the Landlord and Tenant Act has provided some measure of "security of tenure" to tenants in Ontario. If a landlord wishes to evict a tenant then he may only do so if he has a reason and the reason is one set out in the Act. This is regardless of whether or not there is a written lease. No longer can a landlord evict a tenant because he doesn't like him or her. The reasons for eviction include, among others, non-payment of rent, damage to the premises, interference with other tenants and a desire by the landlord or his or her family to move into the premises. In order to have the tenant evicted the landlord must go to Court and obtain a Court Order to that effect.

(b) Privacy

The Landlord and Tenant Act addresses this problem in s.93 as follows:

> "93. Except in cases of emergency and except where the landlord has a right to show the premises to prospective tenants at reasonable hours after notice of termination of the tenancy has been given, the landlord shall not exercise a right to enter the rented premises unless he has firtst given written notice to the tenant at least twenty-four hours before the time of entry, and the time of entry shall be during daylight hours and specified in the notice except that nothing in this section shall be construed to prohibit entry with the consent of the tenant given at the time of entry."

It is an offense to breach these provisions, and a conviction carries a fine of up to $2,000.00.

(c) Distraint (Seizing and holding of a tenant's belongings for non-payment of rent)

2.86 of the Landlord and Tenant Act prohibits distraint. If a landlord is owed rent, he must sue the tenant for it, not use the self-help remedy of seizing the tenant's belongings. The Act makes it an offence to distrain with a conviction carrying a maximum fine of $2,000.00. The Act also provides a relatively quick means of applying to Court to have the goods returned if they are unlawfully distrained by the landlord.

(d) Repair

S.96 of the Landlord and Tenant Act sets out the repair obligations for both landlords and tenants, and a procedure for enforcing them. Landlords are responsible for "providing and maintaining the rented premises in good state of repair and fit for habitation during the tenancy and for complying with health and safety standards, including any housing standards required by law, and notwithstanding that any state of non-repair existed to the knowledge of the tenant before the tenancy agreement was entered into." Tenants are "responsible for the ordinary cleanliness of the rented premises and for the repair of damage caused by his wilful or negligent conduct or that of persons who are permitted on the premises by him." A summary procedure in applying to the Court to enforce these obligations is provided. In addition, the Act provides a prohibition against the landlord

> withholding vital services, such as heat. This is enforced through the imposition of a fine.

Apart from the Landlord and Tenant Act certain other laws exist that affect both tenants and occupants of rooming and boarding houses. For example:

> Municipalities may enact by-laws which deal with such matters as standard of repair of property and, as is the case in the City of Toronto, with the licensing of rooming houses. Such by-laws give certain protections but usually the standards are minimum ones that depend on the municipality rather than an individual enforcing them. The municipality's view of when action should be taken is not always the same as the individual's.
>
> The Innkeepers Act, R.S.O. 1980, C.2.7, is provincial legislation that gives an innkeeper, boarding house keeper, or lodging house keeper, "a lien on the goods of his guest, boarder or lodger for the value or price of any food or accommodation furnished to him or on his account". If part of the debt, amounting to at least one week's board or lodging, remains unpaid for three months then the goods can be sold.

There is also a body of common law that has developed that affects tenants and licensees. Most of the law dealing with tenants has now been codified in the Landord and Tenant Act but that dealing with licensees may have some relevance. For example:

> The common law speaks to the issues of eviction and privacy. For example, while the common law would not grant security of tenure to licensees it at least gives them the right to "reasonable notice" prior to eviction. With regard to privacy it would allow licensees (if a fee is paid for their accommodation) to sue the owner for breach of their right to exclusive possession of their premises if the owner's intrusion could be said to breach that right. Unfortunately, this is of little practical assistance. The Court processes that would be involved are slow, cumbersome and require access to legal services which in themselves can be expensive.

Conclusion

We are left then in a situation where no real protection is given to those who are deemed not to be covered by the Landlord and Tenant Act. This is particularly troublesome since these are the people who are the most vulnerable and thus particularly require protection.

However, it should not be felt that the mere inclusion of occupants of rooming and boarding houses in the Landlord and

Tenant Act will solve the problems of housing for ex-psychiatric patients. Only some of them will be able to "make it" living in housing operated in the private market by private individuals with no adjunct support services. Along with protections, inclusion in the Landlord and Tenant Act will also bring obligations to the tenant, for example, a tenant who wishes to vacate must give the landlord 28 days written notice if a weekly tenant and 60 days written notice if a monthly tenant. In addition, tenants themselves have found that the protections offered by the present Landlord and Tenant Act are often difficult to enforce. If a landlord wishes to operate outside the law, it requires a great commitment of time and resources on the tenant's behalf to force the landlord to obey the Act's provisions. Also it is questionable whether the Act in its present form is adequate to deal with the quality of services supplied, such as meals. However, even with these problems it would be a step forward to amend the Landlord and Tenant Act to make it clear that occupants of rooming and boarding houses are covered by its provisions. There is no rationale for maintaining occupants of rooming and boarding houses in a different and secondary position vis-a-vis the "traditional" tenant. The Ontario Legislature recognized this when it saw fit to include such occupants in the provisions of The Residential Tenancies Act which was to replace the present Landlord and Tenant Act. The Residential Tenancies Act was intended to combine in one act all legislation dealing with landlord and tenant, and rent review matters. The current Landlord and Tenant Act dealing with residential tenants was not to be in force when The Residential Tenancies Act was proclaimed. However, due to the Supreme Court of Canada's finding of unconstitutionality only those provisions in The Residential Tenancies Act that deal with rent review were proclaimed and the Landlord and Tenant Act continues in force.

For those ex-psychiatric patients who require support services in addition to housing, we are looking at a different type of housing and one that in our opinion is not appropriately delivered by the private sector in traditional rooming and boarding house situations. A great many more group homes with adjunct support services must be provided. Legislation such as the Landlord and Tenant Act is not appropriate to govern the relationship between the occupants and the providers of such housing, and resources must be committed by the Ontario Government to developing, in consultation with ex-psychiatric patients and community workers, additional legislation that is appropriate to such relationships.

APPENDIX D: GREATER VANCOUVER MENTAL HEALTH SERVICE

VENTURE

In-Patient and After-Hours Psychiatric Emergency Service (A.H.P.E.S.)

Expenditures 1982/1983

Venture Salaries including A.H.P.E.S. and on-call (not including on-call psychiatrists)*	$435,046
Employee Benefits:	45,983
Total Salaries and Benefits	$481,029
Fixed Asset Expenditures: (frozen in 1982/83 except for emergencies)	2,981
General Operating Expenses	36,460
Total G.V.M.H.S. Expenditures	520,470

Provincial Funds paid direct:

Cook	$20,000
Rent	25,000

* Psychiatrists from the community care teams are available to the A.H.P.E.S. on a weekly rotation basis through an on-call and call-out system. G.V.M.H.S. reports that this system is very expensive and must be negotiated in advance.

From: Financial Statement
March 31, 1983

APPENDIX E: PROPOSED CRISIS CENTRE (15 RESIDENTS)

FUNDING ESTIMATES

STAFFING

1	Coordinator	$ 31,500	
6	Nurses	152,400	
6	Health Care Workers	120,000	
1	Secretary	17,500	
1.5	Cooks	29,000	
	Vacation Relief	22,000	
	Shift Premium	7,000	
	On-Call Staff	4,500	
	On-Call Psychiatrists	64,000	
	Sessional (3)	27,900	$475,800
	Employee Benefits 15%		71,370

OTHER EXPENSES

Lease - Automobile	$ 3,000	
Office Supplies	5,000	
Telephone	3,500	
Travel	3,000	
Maintenance and Janitorial	3,500	
Staff Education	3,500	
Bookkeeping Services	7,500	
Audit Services	2,500	
Insurance	4,000	
Legal	1,500	
Advertising	2,500	
Food Cost	16,500	
Kitchen Supplies	3,000	
Kitchen Equipment	5,000	
Furniture	15,000	79,000
TOTAL		$626,170

NOTES TO PROPOSED FINANCIAL ESTIMATES

1) Provision for rent, property taxes and utilities were excluded.

2) Kitchen equipment and furniture purchases are one time expenditures.

3) Renovation cost has not been taken into consideration.

4) Provision for psychiatrists on call and sessional will require future review.

Prepared with the assistance of Ontario Ministry of Health, but modified due to response to the Preliminary Report.

APPENDIX F: LIST OF PEOPLE CONSULTED DURING THE COURSE OF THE TASK FORCE: February 1983 - January, 1984

1983	ORGANIZATION	INDIVIDUALS
February	Mayor's Office	David Goyette
	Department of Public Health	Dr. A. S. Macpherson
	Ward 7 City of Toronto	Alderman David Reville
	Ward 2 City of Toronto	Alderman Ben Grys
	Department of Planning and Development	Dan Burns
	Local Board of Health	Executive Alderman Anne Johnston
March	Clarke Institute of Psychiatry	Paula Goering Joy Rogers
	Ward 2 City of Toronto	Alderman Chris Korwin-Kuczynski
	Department of Housing	Comm. G. C. Cook
	Ministry of Health	Dr. Boyd Suttie David Corder Ray Berry Giah Eisenstein
	Ward 7 City of Toronto	Ald. David Reville
	Supportive Housing Coalition	Steve Lurie
	On Our Own	Don Weitz Carla McKague
	Parkdale Activity & Recreation Centre	Mary Stern Pat Capponi
	Nellie's Hostel	Alison Guyton

	Department of Public Health	Dr. Edgar Wong
	Queen Street Mental Health Centre	John Trainor Kirsten McDonald
	Houselink	Leah Carragato Meg Sears
	York Community Services	Joan Milling Barbara Titheringham Dr. Donald Cole
	Metro Community Services	Comm. J.R. Picherack Maureen Quigley
	Friends of Schizophrenics (London, Ontario)	Susan Boone
	Canadian Mental Health Association (Ontario Division)	Mary Ellen Polak
	Metro District Health Council	Evelyn Kent Carol Montagnais
	Ministry of Municipal Affairs and Housing	Murray Wilson
April	Ministry of Community and Social Services	Graham Lethbridge
	Department of Planning and Development	Brian Milne
	Ministry of Health Patients' Advocate Program	Dr. Ty Turner Joan Best
	Department of Planning and Development	Dan Burns
	Community Occupational Therapy Association	Nancy Sidle Diana Anderson
	Parkdale Working Group	Members meeting
	Y.W.C.A., Life Skills Program	Nancy Pridham
	George Brown College, Rehabilitation Through Education	Connie Schwenger Layne Mellanby
	Secretariat for Social Development	Norm Mealing

	Roman Catholic Church	Bishop Wall
	Ward 6 City of Toronto	Alderman John Sewell
	Sistering	Rosalyn Gilbert Elizabeth Grove-White Margot Breton
May	Clarke Institute of Psychiatry	Paula Goering Joy Rogers
	Department of Planning and Development	Brian Milne Ann Pohl
	Hillcrest Office, Department of Public Health	Joanne Copeland, Supervisor
	Community Resource Consultants of Toronto	Ron Ballantyne
		Dr. Colin De'Ath
June	Hillcrest Office, Department of Public Health	Joanne Copeland
	Metro Toronto Police Force	Frank Simone
	Peel Regional Police Force	Inspector Eugene Strickland
	Seaton House	George Romanson
July	Ward 7 City of Toronto	Ald. David Reville
	Office of the Mayor	Mayor Arthur Eggleton David Goyette
	Department of Public Health	Dr. A. S. Macpherson
	Ministry of Health, Legal Branch	Gilbert Sharpe
	Metro District Health Council	Carol Montagnais
	Department of Planning and Development	Dan Burns
	Department of Housing	Comm. G. C. Cook
	Ministry of Health	Giah Eisenstein

August	Clarke Institute of Psychiatry	Dr. Stan Freeman
	Queen Street Mental Health Centre	Laurie Kocial
	Department of Buildings and Inspections	Bob Bonner
		Betty Jane Wylie
	Parkdale Activity & Recreation Centre	Mary Stern
	Clarke Institute of Psychiatry	Dr. Don Wasylenki
	Oolagen Community Services	Jim Wakeford
	Metro Committee on Housing for Low Income Singles	Ald. Joanne Campbell Lynn Morrow
	Ministry of Health	Hon. Keith Norton, Minister
September	Office of the Metro Chairman	Chairman Paul Godfrey
October	City of Toronto Aldermen:	
	Executive Committee:	Tony O'Donohue Fred J. Beavis June Rowlands Anne Johnston
	Ward 1	Derwyn Shea
	" 1	William Boytchuk
	" 2	Ben Grys
	" 2	C. Korwin-Kuczynski
	" 3	Richard Gilbert
	" 3	Joseph J. Piccininni
	" 4	Joe Pantalone
	" 5	Ying Hope
	" 5	Ron Kanter
	" 6	John Sewell
	" 6	Jack Layton
	" 7	Joanne Campbell
	" 7	David Reville
	" 8	Tom Clifford
	" 11	Michael Gee
	Department of Public Health	Dr. A. S. Macpherson
	Ontario Public Service Employees Union (OPSEU)	Sean Usher

	Metro District Health Council	Evelyn Kent Elizabeth Fortune
November	Ministry of Health	Giah Eisenstein Al Ehrlenbusch Bobby Crichton Dorothy L'Oranger
	Department of Planning and Development	Dan Burns
	Office of the Premier of Ontario	Deputy Minister, Dr. Edward Stewart
	Ministry of Health	Deputy Minister, Graham Scott, Q.C.
	Ministry of Community and Social Services	Deputy Minister, Robert M. McDonald
	Metro Community Services	Comm. J. R. Picherack Maureen Quigley Lynn Morrow
	Metro District Health Council	Mary Leonard Edna Beange
	City Legal Department	W. R. Callow, Q.C.
	Department of Housing	Comm. G. C. Cook
	City of Toronto Aldermen:	
	Executive Committee:	Tony O'Donohue
	Ward 10:	Michael Walker
	Office of the Mayor	Mayor Arthur Eggleton David Goyette
	Office of the Metro Chairman	Chairman Paul Godfrey
December	Coordinator, Mental Health Services, City of Rome, Italy	Dr. Paolo Crepet
1984		
January	Association of General Hospital Psychiatric Services	Dr. E. W. Busse
	Dept. of Planning and Development	Dan Burns

Department of Public Health	Dr. A. S. Macpherson Marcia Moss
Office of the Mayor	Mayor Arthur Eggleton David Goyette
Office of the Metro Chairman	Chairman Paul Godfrey
Hospital Council of Metropolitan Toronto:	
Humber Memorial Hospital	Lana Kurczak Bruce Maitland
Queensway General Hospital	Andrea Comrie
Metro Toronto District Health Council	Carol Montagnais
St. Joseph's Health Centre	Sister Margaret Myatt Dr. R. Pinto Susie Barron
St. Michael's Hospital	Dr. deBosset
Wellesley Hospital	Pamela Churchill
Toronto East General Hospital	Allen Prowse
York-Finch General Hospital	Michael O'Keefe
Hospital for Sick Children	Dr. Susan Bradley Tom Clarke
Sunnybrook Medical Centre	Eileen Cunningham Peggy Edwards
Clarke Institute of Psychiatry	Dick Hansen Dr. Georges Voineskos Paula Goering
Toronto Western Hospital	Henry Durost
U. of T. Dept. of Psychiatry	Dr. Robert Buckingham
Hospital Council of Metro Toronto	Dan Drown
Office of the Premier	Prem. Wm. G. Davis
Ministry of Health	Hon. Keith Norton, Minister Doug Bonnell David Corder

APPENDIX G: LIST OF TASK FORCE MEETINGS, TOPICS AND PRESENTERS

1983

Tues. Apr. 13	First meeting of the Advisory Committee.

PUBLIC MEETINGS OF THE TASK FORCE

Tues. May 17	TOPIC: Boarding Homes Mr. George C. Cook, Commissioner of Housing and General Manager of Cityhome: Reported on survey of boarding homes in Parkdale, recently undertaken by Special Committee of the Parkdale Working Group. Susan Herbert of the Ministry of Community and Social Services and Canon Bob Cuyler of the Anglican Church. Joint presentation, reporting on the joint venture of the Ministry and Church, in establishing "Ecuhome".
Tues. June 13	TOPIC: Crisis Management Inspector Clark Winter and Constable Michael Fredrico of Metro Police. Constable Fredrico was a Community Relations Officer at 14 Division, in the neighbourhood of Queen Street Mental Health Centre, and as such, outlined some problems the police have when dealing with crises of ex-psychiatric patients. Anne Harris representing Archway, a counselling and crisis intervention centre in Parkdale. Ms. Harris described some of the problems Archway encounters in these situations. Alison Guyton, representing Nellie's Hostel for Women. Referring to a study entitled "The Role of Nellie's in Providing Psychiatric Aftercare", Ms. Guyton emphasized that a hostel is not an appropriate setting for many ex-patients who need much more counselling and support than the hostel setting can provide.

Tues. July 12 TOPIC: Day Activities

Joint presentation by Corinne Bovard and Marie Chapeskie of Community Resources Consultants of Toronto. Outline of programs and functions of CRCT.

Paula Goering of the Clarke Institute of Psychiatry. Presentation based on the results of the Aftercare Study of 1979 to 1981 by the Clarke Institute and CRCT, funded by the Ministry of Health, Adult Mental Health Branch.

Joint presentation by Diana Anderson and Nancy Sidle of Community Occupational Therapy Associates on services to discharged patients living in boarding homes.

Tues. Aug. 9 TOPIC: Vocational Training

Major Tom Sharegan and Captain G. Pearce of The Salvation Army. Joint presentation outlining their programs and some of their concerns in this area.

Constance Schwenger and Layne Mellanby made a joint presentation of the Rehabilitation Through Education Program at George Brown College, a program started 10 years ago to provide a bridge between the hospital and success in the community.

Cynthia Karlton representing Progress Place located in North York. Progress Place is currently being reorganized from a day treatment program to a clubhouse after the New York, Fountainhouse model.

Shelley Cainer of Community Resources Consultants of Toronto. Presentation was an overview of the rehabilitation system in Toronto.

Wed. Sept. 7 "SPEAK OUT" OF DISCHARGED PSYCHIATRIC PATIENTS - held at Parkdale Activity & Recreation Centre.

Topics of Discussion:

- Income
- Co-ordination of aftercare services
- Housing
- Crisis Intervention
- Hospitalization

Everyone was welcome but only current and discharged psychiatric patients were invited to speak.

Wed. Nov. 30 PUBLIC HEARING - held in Council Chambers, Toronto City Hall

TOPIC: Discussion of the Preliminary Report of the Mayor's Action Task Force on Discharged Psychiatric Patients

DEPUTATIONS:

Lindy Laird	Parkdale Community Health Centre Committee
Sean Usher	OPSEU
Pat Capponi	Editor, Cuckoo's Nest
Margaret Frazer	Mental Health Coalition, East Area
Jay MacGillivray	Nellie's Hostel
Jim Robson	Concerned Citizen
Annick Aubert	Concerned Citizen
Irene Harris	Labour Council
Diane Capponi	Mental Health Consumer
Mel Bornstein	Member of Progress Place
Marge Murphy	Rehab. Services of the Clarke Institute
Jackie Rankine	Parkdale Activity & Recreation Centre

Donald Dal Bianco	Past President, Rest Home Association of Ontario
Don Weitz	Mental Health Consumer
Ald. David Reville	City of Toronto
John Hood	Mental Health Consumer
Peggy Schulz	Education & Advocacy Committee of the Supportive Housing Coalition
Ed Negridge	Boarding and Lodging House proprietor
Mary Trichilo	Presenting Communique from Tony Ruprecht, M.P.P., Parkdale.

APPENDIX H: RESPONSE TO REPORTS FROM THE CITY OF TORONTO SPECIAL COMMITTEE ON BOARDING AND LODGING HOUSES IN WARD 2, AND FROM THE CITY OF TORONTO SPECIAL COMMITTEE ON A SPECIAL HOUSING BY-LAW.

Prior to my appointment as the Chairperson of the Mayor's Action Task Force on Discharged Psychiatric Patients, City Council established two special committees with mandates to examine different aspects of issues related to discharged psychiatric patients: a) The Special Committee on Boarding and Lodging Houses in Ward 2 which has been chaired by Alderman Ben Grys, and b) The Special Committee on a Special Housing By-law chaired by the Medical Officer of Health.

In keeping with direction from Council, The Special Committee on Boarding and Lodging Houses in Ward 2 forwarded its Final Report to me in November, 1983. This Report contains 5 recommendations regarding boarding and lodging houses and 3 recommendations regarding group homes. These recommendations are as follows:

Boarding and Lodging Houses

1. That the Zoning By-law be amended so as to permit boarding or lodging houses in all R2, R3 and R4 areas throughout the City.

2. That the Zoning By-law be amended so as to provide that a new boarding or lodging house will not be permitted in Ward 2 any closer than 200 feet from an existing residential care facility or existing boarding or lodging house.

3. (a) Council direct the Commissioner of Planning and Development to undertake a review or study in respect of land use planning policies in the area of Ward 2 bounded by Bloor Street on the north, Dufferin Street on the east, Parkside Drive on the west and Queen Street on the south;

   (b) Council be requested to pass a resolution along the following lines:

   > Whereas a review or study of the land use planning policies in the area of Ward 2 bounded by Bloor Street on the north, Dufferin Street on the east, Parkside Drive on the west, and Queen Street on the south, is to be undertaken, and
   >
   > Whereas under Section 37 of the Planning Act, Council must pass a by-law or resolution to

undertake a review or study of an area before an interim control by-law for that area may be adopted,

It is resolved that Council direct the Commissioner of Planning and Development to undertake a review or study of the land use planning policies in the aforesaid area;

(c) Council be requested to pass an interim control by-law prohibiting new boarding or lodging houses in the aforesaid area for a period of one year from the date of the passing of the by-law, and

(d) Council request the Commissioner of Planning and Development to complete his review or study within a six-month period, and report back thereon to the Land Use Committee.

4. That Council endorse the principle that a high standard of psychiatric care must be made available in all hospitals and a high standard of support services be made available throughout the Province, thus supporting the principle of decentralization of psychiatric care services, and that the Province be so advised.

5. That Council advise the Province of Ontario that it is the view of Council that municipalities which have a large number of ex-psychiatric patients should be compensated with funds which would be directed to better housing and support systems for ex-psychiatric patients.

6. That the Special Committee on a Special Housing By-law be requested to give consideration to the contents of a Personal Health Care By-law which could be enacted for the City.

Group Homes

1. That the Province should be required to notify the community before setting up a group home (residential care facility).

2. That the present 800-foot by-law be amended to read 2,000 feet.

3. That in view of the adoption of the group home by-law into Metroplan, the Provincial Government be urged to locate new group homes outside the City of Toronto, and in particular, outside Ward 2 and other Wards in the City of Toronto which presently have 12 or more group homes.

As requested by Council in February, 1983, (Clause 22 of Report #11, adopted as amended February 21 and 25, 1983) I have reviewed these recommendations and now make the following Report to Council as to my response.

Regarding Boarding and Lodging Houses

Recommendations 1, 2 and 3 all focus on matters of zoning specific to Ward 2 which are properly within the expertise of the Commissioner of Planning and Development. The Land Use Committee has requested that the Commissioner of Planning & Development report on these recommendations to Council and I am of the opinion that this is most appropriate.

Recommendation 4 is consistent in principle with the findings in my Final Report on the need for greater involvement by general hospitals in the delivery of services to discharged psychiatric patients and is supportable. As well, I have made recommendations consistent with the intent of Recommendation 4 regarding the high level of support services needed throughout the Province, but by virtue of my Task Force mandate, I have made recommendations specific to the Toronto area. My recommendations have been based on numerous consultations with politicians and officials of the City, Metro and Province and I have received positive responses from those consulted.

Recommendation 5 is also consistent with the thrust of my final recommendations. In particular, my proposal for the Contract Aftercare Project (C.A.P.) for upgrading boarding homes located throughout the City which cater primarily to discharged psychiatric patients is to be funded by the Province but implemented through joint efforts on the part of the City, Metro and the Province. I have also made recommendations directed to better support systems for ex-psychiatric patients. Accordingly, I would urge Council to adopt this recommendation.

Recommendation 6 is directed to the Special Committee on a Special Housing By-law (originally entitled the Special Committee for a Personal Care By-law) chaired by Dr. A. S. Macpherson, the Medical Officer of Health for the City. This Special Committee was established by Council in October of 1982 (Clause 17 of Report 18 of the Land Use Committee, adopted as amended on October 7, 8, 1982) and held its first meeting on January 5, 1983. When Council adopted the establishment of the Mayor's Action Task Force on Discharged Psychiatric Patients to be chaired by me, it directed that:

> "The Special Committee on Boarding and Lodging Houses in Ward 2 and the Special Committee on a Special Housing By-law to proceed with their work in coordination with the Task Force, and to report their findings to the Task Force."

(Clause 22 of Report #11, adopted as amended
February 21 and 25, 1983.)

As I understand the mandate of the Special Committee on a Special Housing By-law, it is to do precisely that which is requested in Recommendation 6 of the Final Report of the Special Committee on Boarding and Lodging Houses in Ward 2. I have not received a report from the Special Committee on a Special Housing By-law. However, as explained in my Preliminary Report (Housing chapter), I have come to the conclusion that an additional by-law directed at standards of care for discharged psychiatric patients is not the most effective approach for the City to take at this time. In reaching this conclusion, I consulted with many officials and politicians, including many of the members of the Special Committee on a Special Housing By-law. I remain satisfied that the enactment of a "personal care by-law" is not something I am prepared to recommend. However, I consider Recommendation 6 supportable in that it pertains to what the Special Committee on a Special Housing By-law has already been directed by Council to do.

Regarding Recommendations for Group Homes

Recommendations 1, 2 and 3 all raise zoning issues which are currently being studied by the Department of Planning and Development. The Commissioner will be reporting to Council on these recommendations as well as Recommendations 1, 2 and 3 regarding Boarding and Lodging Houses, and I am satisfied that such a Report would be the most appropriate response.

POOR

QUALITY

ORIGINAL